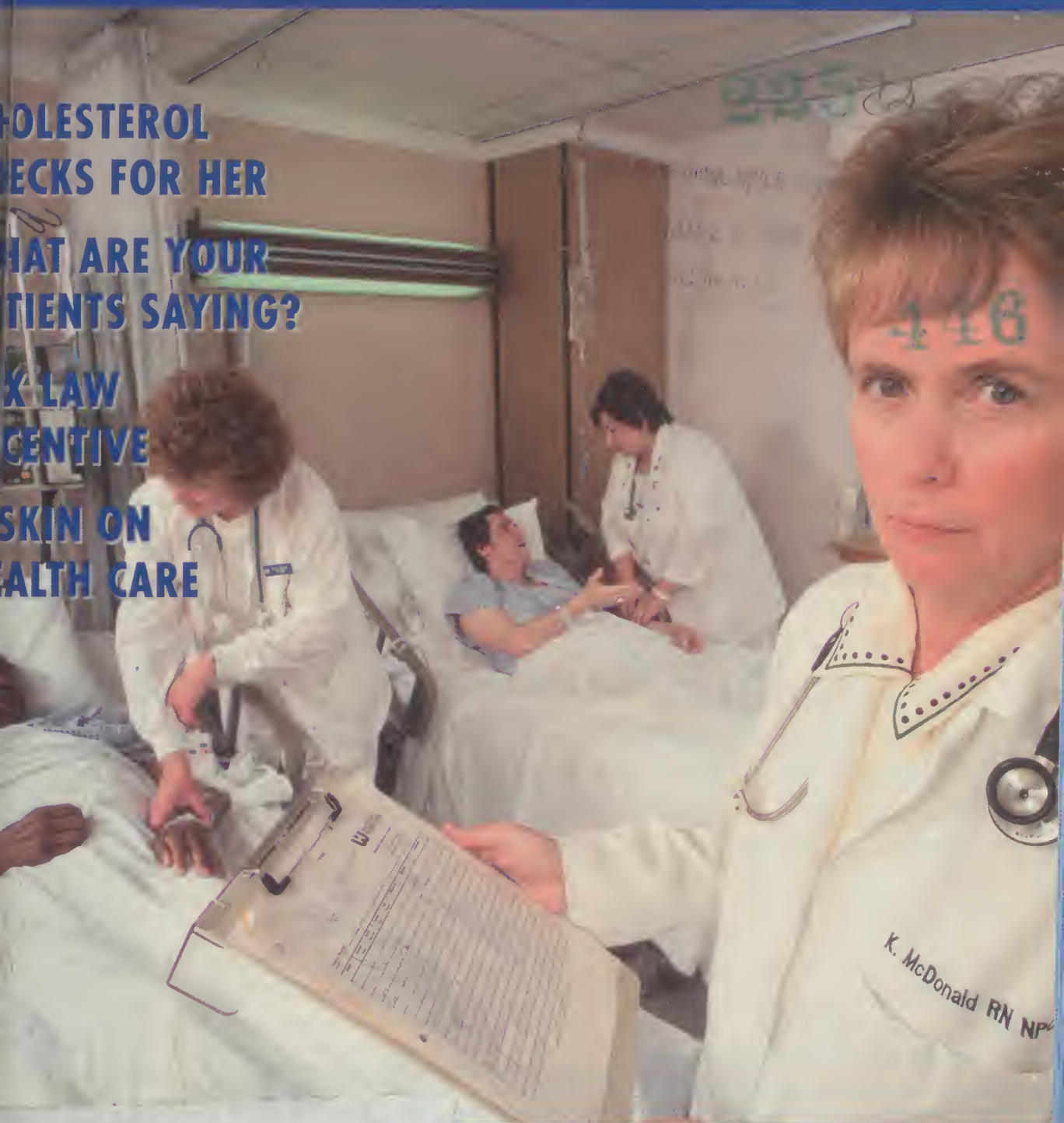


New Jersey MEDICINE

Health Care in the Garden State

January 1998

**CHOLESTEROL
CHECKS FOR HER
WHAT ARE YOUR
PATIENTS SAYING?
K LAW
CENTIVE
SKIN ON
HEALTH CARE**



as Medical Assoc
Journal Office
1 West 15th St
stin, TX 78701

**Nursing and managed care:
Where do they stand?**

Y - O - U - R

PRACTICE

MADE MORE

PERFECT

WITH OVERHEAD EXPENSE INSURANCE FROM BLANKSTEEN

If you get sick, we'd like to help keep your practice well with overhead expense coverage that can reimburse office salaries, rent, insurance premiums, and utilities during an extended disability. Your needs are special, so call and talk with us. The only time to draw a blank in your insurance is when you fill it in with Blanksteen.



The _____ steen Companies

The Blanksteen Companies 253 Washington Street Jersey City, NJ 07302 201-333-4340 1-800-BLANK-AG
The Blanksteen Companies 161 William Street New York, NY 10038 212-732-9435 1-800-BLANK-AG
The MEDICAL SOCIETY OF NEW JERSEY endorsed plans, including Professional Overhead Expense underwritten by National Casualty Company.

JAN 22 1998

AUSTIN, TEXAS

New Jersey MEDICINE

newsWATCH

The American Medical Accreditation Program (AMAP) has been officially introduced. The program is the first state-level partnership with the Medical Society of New Jersey (MSNJ), its subsidiary the Medical Review and Accrediting Council, Inc. (MRAC), and NYLCare of New Jersey. AMAP focuses on quality and responsiveness to the information needs of all members of the health care community.

Aren't physicians subject to accreditation already? How is AMAP different? Prior to the development of AMAP, there was no national, standardized program for individual physician accreditation. There are many diverse forms of evaluation, but there are no standardized, nationally accepted processes that combine the individual components of AMAP.

Why was AMAP developed? AMAP was developed in response to the tremendous pressures that physicians, along with health plans and hospitals, face on a daily basis to reduce costs while simultaneously devoting increased time and effort to continuously documenting and enhancing quality. AMAP provides a unique and practical way for the health care community to define, demonstrate, and document quality.

What is MSNJ's role in the introduction of AMAP? MRAC, a subsidiary of MSNJ, is the AMA's exclusive

state partner in the introduction of AMAP in New Jersey. As a state partner, MRAC provides credentials verification organization and environment of care (office site review) services within the state. MRAC participates with the AMA in the marketing and communication of AMAP to all physicians, health plans, hospitals and health systems, employers, and the general public.

Is AMAP accreditation a substitute for or equivalent to board certification? AMAP has never and will never equate itself with board certification. Board certification attests to the satisfactory completion of a course of education and training in a medical specialty, as well as to the satisfactory passage of examinations that test an applicant's level of knowledge in that medical specialty. AMAP accreditation and board certification are best viewed as complementary processes.

How do clinical performance and patient care results fit into the AMAP accreditation program? One of AMAP's goals is to provide a single source for credible, consistent, and comprehensive information on physician quality. AMAP seeks to eliminate multiple, fragmented, and often conflicting, performance criteria as well as duplicative processes. Components Four and Five of the program are consistent with AMAP's goals. These developing components ensure: individual physicians participate in continuous quality measurement systems; systems available to physicians are credible and uniform; and data collected at the physician level for AMAP can be

aggregated to meet the needs of other credentialing organizations to avoid redundancy.

Are Components Four and Five compatible with the quality initiatives of medical specialty societies?

Components Four and Five are developing with collaborative input from medical specialty societies to ensure their compatibility with the goals and activities of such societies for enhanced care processes and outcomes. AMAP accreditation does not set an arbitrary performance threshold. Rather, the accreditation decision considers an individual physician's participation in performance measurement and improvement systems. AMAP, jointly with specialty and other medical societies and organizations, is developing performance measurement and improvement systems especially targeted to those physicians to whom such quality improvement initiatives are otherwise unavailable.

Can I review the criteria by which AMAP evaluates physicians?

Yes. The standards and criteria used to evaluate the first three components of AMAP—credentials, personal qualifications, and environment of care—are published in a booklet available through the AMAP Resource Center (888-881-AMAP ext. 2627), or from the AMAP web site at <http://uaa.ama-assn.org>. Standards and criteria for Components Four and Five are evolving through the same collaborative process, and as standards are developed and data become available over time, that information also will be published for review.

What do the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the National Committee for Quality Assurance (NCQA) think of AMAP?

AMAP accreditation is to individual physicians what JCAHO accreditation is to hospitals and other health care organizations and what NCQA accreditation is to health plans. AMAP activities are designed to meet or exceed the physician credentialing requirements of JCAHO, NCQA, and other accrediting bodies.

If I receive AMAP accreditation, who will see my individual portfolio of information?

You will see your accreditation results. In addition, the individual health plans and hospitals with which you are affiliated and that purchase AMAP information can receive your portfolio.

If I don't meet the standards in some areas, can I still receive AMAP accreditation?

The AMAP accreditation process measures and evaluates physicians against national standards, criteria, and peer performance in five areas: credentials, personal qualifications, environment of care, clinical performance, and patient care results. Undergoing accreditation is an excellent opportunity for identifying any practice areas that presently may not meet the new national benchmark. These identified areas then can be addressed for consideration in an individual physician's accreditation decision.

How do physicians receive an application or more information?

To receive an application, call 888-881-AMAP, ext. 2627.



NJM

NJM

NJM

NJM

NJM

NJM

NJM

“I KNOW NO
WAY OF JUDGING
THE FUTURE
BUT BY THE PAST.”



PATRICK HENRY, 1775

As a Princeton Insurance Company policyholder, your professional and financial future isn't written in the stars, but in the history books: Princeton has had a long-standing commitment to meet the professional liability insurance needs of doctors. That includes a track record of vigorously defending our insureds against frivolous malpractice claims and a rate structure that rewards doctors with good experience.

To help secure *your* future, consult one of the independent agents who represent Princeton or call us at **1-800-433-0157**.



Princeton Insurance Company

Professional Liability

Office Package Policy

Workers Compensation

Rated A- (Excellent) by A.M. Best Company 746 Alexander Road • Princeton, New Jersey 08540

REVIEW BOARD

Sofia Anthony, MD
 Paul W. Armstrong, Esq
 Richard M. Ball, MD
 Stanley S. Bergen, Jr, MD
 Harry M. Carnes, MD
 Gary S. Carter
 Elizabeth G. Christopherson
 Ellen M. Cosgrove, MD
 The Honorable Len Fishman
 Joseph E. Gonzalez, Jr
 Paul J. Hirsch, MD
 Ismail Kazem, MD
 Louis L. Keeler, MD
 Carol J. Kientz, RN
 James R. Knickman, PhD
 Paul R. Langevin, Jr
 George R. Laufenberg
 Martin S. Levine, DO
 Henry R. Liss, MD
 Gregg Lubinsky, RPH
 Ruth B. Mandel
 Michael R. McGarvey, MD
 Julane Miller
 Charles M. Moss, MD
 Patricia Murphy, PhD, RN
 Tom O'Neill
 Fred M. Palace, MD
 Mary Todd, DO
 William H. Tremayne
 F. Kevin Tylus
 The Honorable Charlotte Vandervalk
 Joan Verplanck
 Paul E. Wallner, DO

COUNCIL ON COMMUNICATIONS

Charles M. Moss, MD, Chair
 Harry M. Carnes, MD,
 Vice-Chair
 Henry R. Liss, MD, Vice-Chair
 Richard M. Ball, MD
 John P. Capelli, MD
 Paul J. Carniol, MD
 Andrew B. Covit, MD
 Anthony Del Gaizo, MD
 Joseph A. DiLallo, MD
 Michael J. Doyle, MD
 Leigh E. Ende, MD
 Steven C. Fiske, MD
 Jack Goldberg, MD
 Daniel P. Greenfield, MD, MPH
 George H. Hansen, MD
 M. Arif Hashmi, MD
 Christine E. Haycock, MD
 Walter J. Kahn, MD
 Monroe S. Karetzky, MD
 Ismail Kazem, MD
 Louis L. Keeler, MD
 Scott P. Keil, MD

Joseph W. Kozielski, MD
 Clement H. Kreider, Jr, MD
 Alan J. Lippman, MD
 Robert M. MacMillan, MD
 Donald W. Orth, MD
 Robert M. Pallay, MD
 Sindy M. Paul, MD
 Arthur W. Perry, MD
 Niranjana V. Rao, MD
 Kelly M. Reid, MD
 Carl Restivo, Jr, MD
 John C. Riggs, MD
 R. Gregory Sachs, MD
 John D. Slade, MD
 Bessie M. Sullivan, MD
 Julie E.K. Timins, MD
 Sandra S. Valdez, MD
 Paul E. Wallner, DO
 Richard A. Williams, MD
 Angie Campo
 Eileen Martin Cohen
 Anna Miranda

New Jersey MEDICINE

Health Care in the Garden State

EDITOR-IN-CHIEF

Howard D. Slobodien, MD

EXECUTIVE EDITOR

Geraldine R. Hutner, MA

ASSISTANT EDITOR

Nancy M. Profsner, BA

ADVERTISING

Cookson Media Services

PRODUCTION

Trentypo, Inc.

PRESIDENT AND CHAIR

Carl Restivo, Jr, MD

PRESIDENT-ELECT

R. Gregory Sachs, MD

FIRST VICE-PRESIDENT

Irving P. Ratner, MD

SECOND VICE-PRESIDENT

Walter J. Kahn, MD

SECRETARY

Bessie M. Sullivan, MD

TREASURER

Eileen M. Moynihan, MD

IMMEDIATE PAST-PRESIDENT

Anthony P. Caggiano, Jr, MD

BOARD OF TRUSTEES

S. Manzoor Abidi, MD

Stevan Adler, MD

Angelo S. Agro, MD

Churchill L. Blakey, MD

Donald J. Cinotti, MD

Rajendra Prasad Gupta, MD

David A. Ingis, MD

Philip J. Jasper, MD

Elliot M. Kraus, MD

Giovanni Lima, MD

Mark T. Olesnick, MD

Robert S. Rigolosi, MD

Michael J. Spedick, MD

John W. Spurlock, MD

J. Jerome Cohen, MD, OMSS

Andrew Kunish, MD, Speaker of the House

Susan Kahn, MSNJ Alliance

John Y. Lee, Medical Student

Daniel M. Greenwald, MD, Medical Specialty Societies

New Jersey MEDICINE (ISSN-088-5842-X) is published monthly (since 1904) under the direction of the Council on Communications by the Medical Society of New Jersey (MSNJ), Two Princess Road, Lawrenceville NJ 08648. Printed in Lancaster, PA, by Lancaster Press. Printed in USA. Whole number of issues 1123. Member's subscription (\$10) is included in MSNJ dues. Rates for nonmembers are \$50; outside of USA, add \$20. Single copy is \$7.50. Periodicals postage paid at Trenton, NJ, and Lancaster, PA. Copyright 1998 by MSNJ. January 1998. Internet address: <http://www.msnj.org>. E-mail address: info@msnj.org. 609/896-1766. FAX 609/896-1368. Postmaster: Send address changes to New Jersey MEDICINE, Two Princess Road, Lawrenceville NJ 08648. The appearance of advertising in New Jersey MEDICINE is not a MSNJ guarantee or endorsement of the product or service, by the advertiser. When MSNJ has endorsed a product or program, that will be expressly noted.



Critical Treatment for the Future of Your Practice...



Before It's Too Late

Wilentz, Goldman & Spitzer's Health Care Law Practice Group serves health care professionals regarding: group practice formation and operations; management service organizations (MSOs); physician practice management companies (PPMCs); managed care contracting; physician-hospital organizations (PHOs); independent physician associations (IPAs); restrictive covenants; and regulatory, employment, tax and litigation matters. **Think of us as preventive medicine for your practice.**

For information please call our Health Care Law Practice Group Co-Chairs: Michael F. Schaff at (732) 855-6047 or Francis V. Bonello at (732) 389-5636.

**WILENTZ
GOLDMAN
& SPITZER**
ATTORNEYS AT LAW

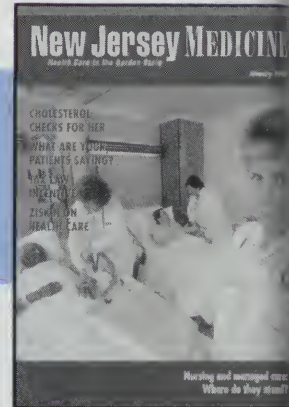
**"Helping The Health
Care Professional"**

Woodbridge, NJ
New York, NY
Eatontown, NJ

<http://www.newjerseylaw.com>

CONTENTS

- 23** IN THE SPOTLIGHT
Interview with Leah Z. Ziskin, MD, MPH
By Bill Berlin, PhD
- 27** HEALTH CARE FEATURE
How managed care affects nursing
By David M. Price, MDiv, PhD; Patricia A. Murphy, PhD, RN, CS
- 31** CLINICAL REPORT
Duodenal perforation: The laparoscopic perspective
By Ibrahim M. Ibrahim, MD; Barry Sussman, MD; Fred Wolodiger, MD; Fred Silvestri, MD
- 35** PUBLIC HEALTH ADVANCES
Getting to the heart of the problem: Women and cholesterol
By Bill Berlin, PhD
- 39** PUBLIC HEALTH
Public health and medicine: Working together
By Marilyn A. Gorney, DO; Cindy M. Paul, MD, MPH; Martin T. Zanna, MD, MPH; Leah Z. Ziskin, MD, MPH
- 43** SPECIAL REPORT FEATURE
Prescription for effective communications with older patients
By Phil Bruschi
- 47** LEGAL UPDATE
Breaching physician-patient confidentiality to protect public welfare
By Russell L. McIntyre, ThD
- 53** FINANCIAL MATTERS
New opportunities under the 1997 tax law
By Frank Castellon
- 57** POINT COUNTERPOINT
Health care and the English language
By Bernard S. Strauss, MD
- NEWSWATCH 1**
- MAIL STOP 10**
- NEWSMAKERS 14**
- ONLINE MSNJ 17**
- EDITOR'S DESK 19**
- MEMBERSHIP MATTERS 21**
- COMPUTERS IN MEDICINE 59**
- CALENDAR 62**
- F.Y.I. 72**

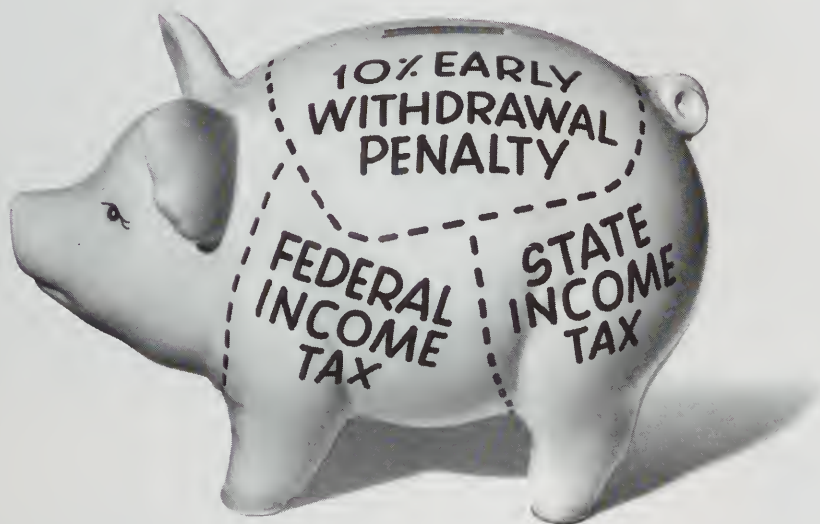


©Conrad Glos

Is organized nursing less threatened by managed care than organized medicine? The story begins on page 27.

Cover: © Conrad Glos

Switching Jobs Can Have An Unfortunate Effect On Your Retirement Savings.



**Don't Lose 40% Or More Of Your Retirement Plan To Taxes And Penalties.
Call For Your Free Information Kit Today.**

If you've switched jobs, the way you handle the payout from your former employer's retirement plan is very important. This may be one of the largest sums you'll ever receive. And, depending on what you choose to do, you could lose 40% or more of it to federal, state, and local taxes as well as early withdrawal penalties. It makes sense to know the facts before you act.



T. Rowe Price can help. We offer a free kit that clearly explains the options in plain, straightforward language. You'll learn the pros and cons of each distribution option and how to avoid the potential taxes and

penalties. And if you choose a rollover IRA from T. Rowe Price, you'll have access to our knowledgeable customer representatives, who can help make the rollover process as easy and hassle-free as possible.

Request your free kit today. Call us and we'll send you our free kit on managing your retirement plan distribution, which includes the tools you need to help you decide what's best for you. We'll also include information about our broad range of no-load mutual funds. Call our toll-free number today. Because we'd

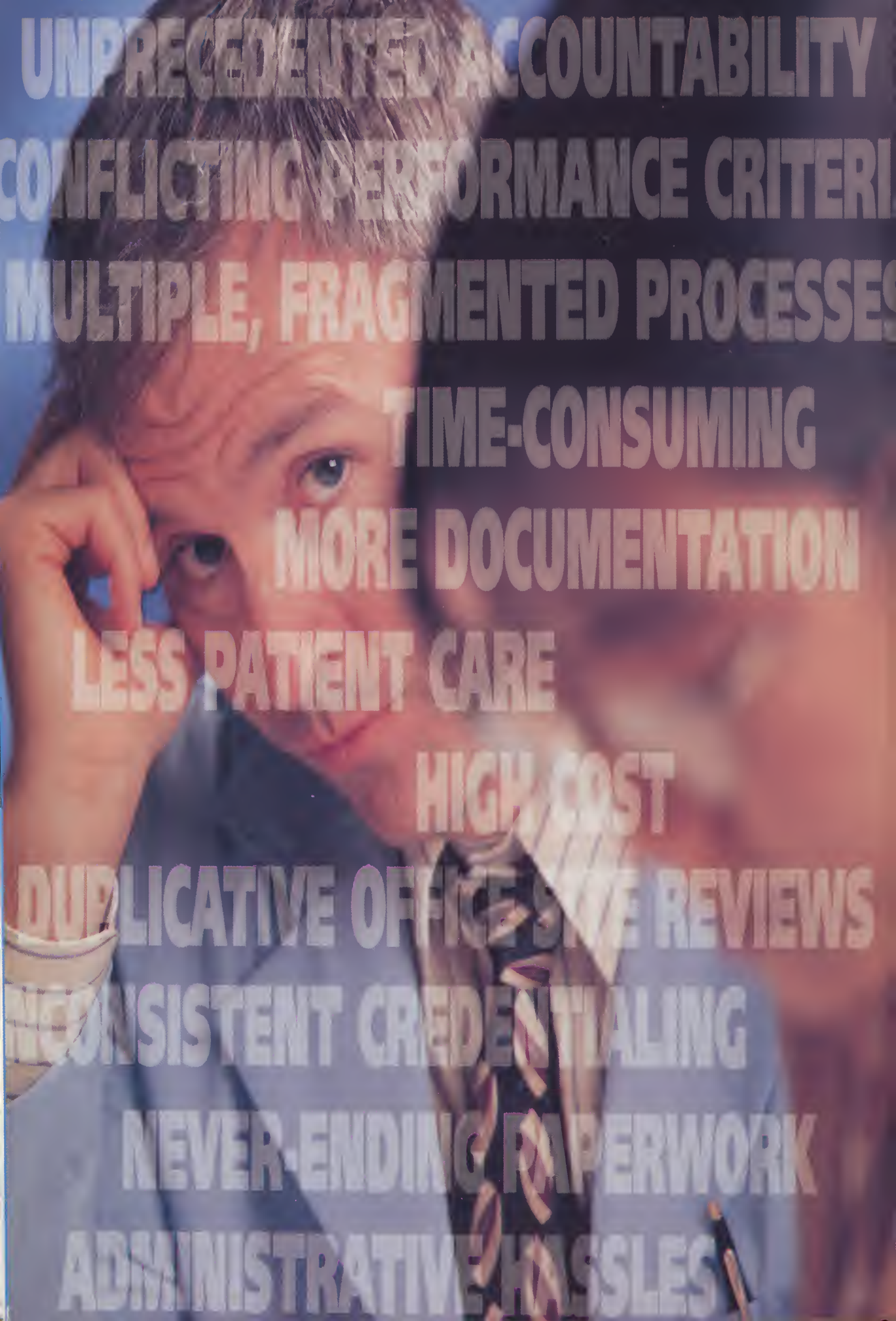
hate to see your retirement plan go all to pieces.

1-800-541-4745

Invest With Confidence®
T. Rowe Price 

Request a prospectus with more complete information, including management fees and other charges and expenses. Read it carefully before you invest or send money. T. Rowe Price Investment Services, Inc., Distributor.

IRAR040027



UNPRECEDENTED ACCOUNTABILITY
CONFLICTING PERFORMANCE CRITERIA
MULTIPLE, FRAGMENTED PROCESSES
TIME-CONSUMING
MORE DOCUMENTATION
LESS PATIENT CARE
HIGH COST
DUPLICATIVE OFFICE-SITE REVIEWS
INCONSISTENT CREDENTIALING
NEVER-ENDING PAPERWORK
ADMINISTRATIVE HASSLES

our solution has arrived.

One Time

One Source

One Standard



American
Medical
Accreditation
Program

With the new American Medical Accreditation Program (AMAP), physicians complete an application **ONE TIME**, have their credentials primary-source verified **ONE TIME**, and have an on-site office review **ONE TIME**.

AMAP then provides an Accreditation report and certificate to each physician who meets the AMAP national standard.

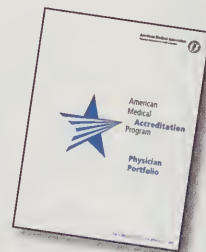
Next, AMAP will provide a complete portfolio of verified credentials, office site review and other frequently requested information to each health plan and hospital that uses AMAP and with whom the physician is affiliated.

The American Medical Accreditation Program is a voluntary, comprehensive accreditation program that measures and evaluates individual physicians against national standards, criteria and peer performance in five areas: **Credentials, Personal Qualifications, Environment of Care, Clinical Performance, and Patient Care Results.**

Meeting and maintaining AMAP's high standard earns a physician AMAP Accreditation – a new national benchmark of physician quality.

AMAP, your one source for the new national standard of physician quality information, has arrived.

To learn more about the many benefits AMAP has to offer *your* organization, call the AMAP Resource Center at 1-888-881-AMAP (2627) or visit the AMAP Web site at <http://www.ama-assn.org>.



The standard in quality physician care.

American Medical Association
Physicians dedicated to the health of America





New Jersey MEDICINE

HMOs at work

Numerous factual errors were contained in Dr. Slobodien's "Editor's Desk" column in the October 1997 edition of *New Jersey MEDICINE*.

For the record, HIP Health Plan of New Jersey will not be acquired by PHP Healthcare Corporation of Reston, Virginia. In fact, HIP and PHP have signed a contract for a 20-year strategic alliance that will strengthen HIP's position as one of New Jersey's leading HMOs.

HIP Health Plan of New Jersey is and remains a not-for-profit HMO.

Approximately 97 percent of our health care center-based physicians were offered and accepted contracts from PHP's affiliated Pinnacle Medical Group. In addition, more than 1,000 non-physician personnel also will transition to a PHP affiliate. This ensures continuity of care for HIP members receiving services at 18 practice sites across New Jersey. Another advantage of this strategic alliance includes the choice for HIP members to receive care at an additional 10 PHP affiliated practice sites (bringing the total to 28) or at thousands of participating community-based physicians in HIP's network.

It also should be noted that HIP's historic focus on quality

continues unabated. HIP recently earned the top New Jersey ranking of HMOs by *U.S. News and World Report*, as described in its October 13, 1997, edition.

We are proud of HIP Health Plan of New Jersey's two decades of quality service to New Jersey employers and residents and look forward to enhancing our Plan as we move into the next century.

Victoria A. Wicks, President and CEO, HIP Health Plan of New Jersey

Reporting the news of HMOs at work

Most of the information in my October 1997 editorial was derived from local newspapers. For example, *The Home News & Tribune (HN&T)* headlined on August 29, 1997: "Va. Firm will acquire HIP Health Plan of N.J." In that issue and in the issue on August 29, the paper was quite clear: "Pending regulatory approval by state and federal agencies, PHP will purchase HIP's 18 health centers . . . as part of the \$73 million deal, PHP will acquire the assets of the 18 HIP health centers and fold them into an existing network called Pinnacle Health Enterprises."

Again, on October 31, 1997 (after my article had been published), *HN&T* emblazoned on page 1: "HIP

takeover coming; downsized staff at area health center angry." The newspaper agreed that almost all the physicians had signed on. But did they sign collectively or as individuals and thereby remove the potential for collective bargaining? Moreover, many employees in New Brunswick were not re-hired, and some of the disgruntled ones threatened job action.

So I suggest you criticize *HN&T* for factual errors; I merely reported its findings.

As for the issue of quality—yet to be determined accurately in most areas of health care delivery—I do not feel that *U.S. News and World Report*, *New Jersey Monthly*, or similar vehicles are qualified to judge HMOs, physicians, or others involved in that delivery. (Even the New Jersey Department of Health and Senior Services has had a hard time with it.) More importantly, how do HMOs and other managed care companies intend to help solve the problem of the more than 40 million uninsureds in this country—by putting it all on others' shoulders?

Thank you for your provocative remarks. It is nice to know that someone reads my scribbles.

*Howard D. Slobodien, MD
Editor-in-chief,
NJ MEDICINE*

continued on page 12



Stuart M. Hochron, M.D., Esq.

Physician Legal Representation

- Group Practice Formation
- Physician Litigation
- Federal Regulation
- Board of Medical Examiners

Practicing Physician, Twenty Years
Clinical Professor, UMDNJ-RWJMS
Research as Highlighted on CNN
AMA Physician Referral Service
Partner, Richmond, Hochron & Burns



phone: (732) 821-0200 fax: (732) 422-9444 e-mail: MDLAWSMH@aol.com

209 North Center Drive North Brunswick, New Jersey 08902

continued from page 10

Health care in the golden years

New Jersey has taken action to address the relative shortage of geriatricians mentioned in the article, "The golden boom: The health needs of seniors" (September 1997) through an established geriatric medicine fellowship training program based at the Department of Family Medicine at UMDNJ-Robert Wood Johnson Medical School, in New Brunswick. The training program for both internal medicine- and family medicine-trained physicians includes one or two years of focused clinical, research, and educational work experiences in the fields of gerontology and geriatric medicine. Clinical training occurs in a wide variety of settings including nursing homes, ambulatory care facilities, and acute and subacute inpatient care centers. Graduates are eligible to take the Certificate of Added Qualifications examination in geriatric medicine from their primary board and many also have elected to obtain public health training during their fellowship.

The 17 graduates from the fellowship program, since its inception in the mid-1980s, have found work in a wide variety of settings and many continue to serve the older residents of our state as well as

teaching in primary care training programs for future physicians.

It also should be noted that both family medicine and internal medicine residents have very well-defined curricula in geriatric medicine during training. This further enhances their ability to care for geriatric patients.

*John M. Heath, MD,
Associate Professor &
Co-Director,
Geriatric Medicine
Fellowship Programs,
UMDNJ-Robert Wood
Johnson Medical School*

*David F. Howarth, MD,
MPH,
Associate Professor &
Director, UMDNJ-Robert
Wood Johnson Medical
School,
Geriatric Medicine
Fellowship Programs,
UMDNJ-Robert Wood
Johnson Medical School*

Interventional cardiology

I was puzzled by an item I read in the September issue. There was mention of a pioneer cardiac procedure describing the use of peripheral vascular angioplasty with stenting by two interventional cardiologists. While it may, in fact, be true that these doctors are the first interventional cardiologists in New Jersey to obtain privileges to perform this procedure, peripheral vascular angioplasties have been performed routinely throughout the state for over two decades. The more recent advent of endovascular stents has expanded the applicability of this technique. Both procedures are performed by vascular surgeons and interventional radiologists.

*James B. Alexander, MD,
President, Vascular
Society of NJ*



Requirements for letters

To submit a letter, FAX (609/896-1368), e-mail (info@MSNJ.org), or mail your letter to *New Jersey MEDICINE*, Two Princess Road, Lawrenceville NJ 08648. Letters should be typed and double-spaced and should be no longer than 400 words with up to 4 references, if necessary. Include your full name, affiliation, address, and telephone number.

Letters are published at the discretion of the editor-in-chief and are subject to editing and abridgment. Letters may be published on MSNJ's web site, <http://www.msnj.org>. Financial associations or other possible conflicts of interest must be disclosed. Letters represent the opinions of the authors.

Introducing the HMO that *protects* your *freedom.*

American Preferred is a managed care company created to offer both Physicians and Members more of what they want...freedom!



Freedom for doctors

At American Preferred, our doctors are free to prescribe treatments without undue policy restrictions or untimely delays. Our Open Recruitment Policy protects your natural referral relationships by giving you the freedom to nominate your colleagues to our network. Our fee-for-service reimbursement philosophy offers further freedom to practice medicine.

bring their family physicians into the network. This freedom also protects the physician-patient relationship.

Freedom for employers

Our HMO and POS products offer simple claims processing with virtually no paperwork. This allows employers to offer their employees a low-maintenance plan with a high degree of acceptance. And a toll-free help line further frees-up employers' administrative time.

Freedom for members

Continuity of care is important to us, so we encourage Members to



Discover

the results of freedom for yourself. Simply call the toll-free number below.

**American Preferred
Provider Plan, Inc.**

Call 1-800-616-1170 for information or a free brochure



Michael J. Kane, MD

Cancer liaison

MSNJ member **Michael J. Kane, MD**, received a three-year appointment as cancer liaison physician for the Hospital Cancer Program at Robert Wood Johnson University Hospital at Hamilton.

Kane joins a national network of over 2,000 volunteer cancer liaison physicians who are an integral part of the Commission on Cancer of the American College of Surgeons. As cancer liaison physician, Kane provides leadership to the cancer committee at Robert Wood Johnson University Hospital at Hamilton. Kane is the medical director at The Cancer Institute of New Jersey at Hamilton.



Drs. Weiss and Stauffer

Positive partnership

Deborah Heart and Lung Center, in Browns Mills, has joined with Trenton's **Mercer Medical Center** to provide pediatric cardiology services to young patients at Mercer Medical Center.

Nanci Stauffer, MD, a board-certified pediatrician and pediatric cardiologist, sees pediatric patients weekly at Mercer Medical Center. She also works with Mercer Medical Center's maternal fetal medicine clinic, performing echocardiograms to diagnosis congenital heart disease in the fetus. Deborah Heart and Lung Center recently opened the William G. Rohrer Neonatal and Pediatric Cardiac Surgical Unit.

Community partnership

New Jersey hospitals serve the community as a critical part of their mission. They provided more than \$407 million in charity care in 1996. Hospitals offered nearly 140,000 community service programs, providing \$8.6 million to administer these programs.

These findings are from the Health Research and Educational Trust of New Jersey's new report entitled, *New Jersey Hospitals: Meeting the Vision of Commitment to Community*. The report provides an overview of New Jersey hospitals and their mission and role in the health of our communities. For a copy of the report, call 609/275-4145.

A shot in the arm for the elderly

The Peer Review Organization of New Jersey and the Newark Department of Health and Human Resources selected **Jeremias Murillo, MD**, to

chair the Provider Committee of the Newark Fights the Flu campaign. Murillo is the president of the Infectious Diseases Society of New Jersey and director of pediatric infectious disease at Newark Beth Israel Medical Center.

The committee is responsible for coordinating health care providers giving flu shots at the campaign's church-based flu shot centers. The goal of the Newark Fights the Flu campaign is to increase the number of Newark's medically underserved senior citizens who receive annual flu vaccinations.



Jeremias Murillo, MD (left), discusses the Newark Fights the Flu campaign with Walter Fields, CEO, of Fields Communications.



continued on page 16

Lower Malpractice Premiums with Managed Care?

The Joseph A. Britton Agency can help make happen! If Managed Healthcare is making you consider joining:

- an IPA,
- a large single or multi-specialty group,
- a staff model HMO, or
- a PPO

Your professional liability insurance costs could actually go down!

With over 25 years of experience, the Britton Agency has proven exceptional in packaging malpractice insurance. Our professional staff and size ensure you the benefits of specialized and personal service while offering you insurance at the lowest cost.

Call us today for a free consultation.
Your career can depend on it!

Joseph A. Britton Agency, Inc.

Healthcare & Professional Liability Insurance

855 Mountain Avenue, Mountainside, NJ 07092

908-654-6464 • Fax 908-654-1422 • 1-800-462-3401

You take care of your patients. We'll take care of the health of your practice. Our group of health care accounting specialists provides the medical community with the right type of analysis and counseling to be successful.

Since we're dedicated to increasing your profitability, never simply reporting it, we'll see

to it that your practice stays healthy for many years to come. To experience our unique approach, please call Ira S. Rosenbloom, Managing Director, at 973-882-1100.

PRACTICE GOOD FINANCIAL MEDICINE.



Mintz Rosenfeld & Company LLC

Profitability Consultants • Certified Public Accountants

60 Route 46 East, Fairfield, NJ 07004

Tel: 201-882-1100 Fax: 201-882-1560

OUR FOCUS IS YOUR SUCCESS.



Joseph T. Hayes, M.D., M.P.H., M.S.M., F.A.C.P.M.

Associate—Specializing in Physician Business and Financial Planning

Licensed in Securities & Insurance

Focus Financial Group, Inc.
Registered Investment Advisor



P.O. Box 4516

Metuchen, New Jersey 08840-4516

Call for a free consultation and brochure

1-800-774-1734

or

732-831-0300

E-Mail: FocusFin@AOL.COM

Business Consultants

- Navigate your practice through the managed care environment
- Ensure the financial health of your practice
- Tax and financial planning
- Tax preparation & bookkeeping

Financial Planning

- Mutual Funds—Stocks & Bond
- Tax Free & Tax Deferred Investments
- Annuities—Money Markets
- Limited Partnerships
- IRA's—SEP's—Profit Sharing—401K's
- Tax Credit Programs
- Retirement & Pension Programs
- Education Planning/College Funds
- Life, Health, & Disability Insurance
- Long Term Health Care

**REGISTERED REPRESENTATIVE OF
CADARET, GRANT & CO.**

200 Valley Road, Mt. Arlington, NJ 07856

Member NASD/SIPC

continued from page 14

People in the news

Vincent D. Joseph has been named executive director at Saint Barnabas Medical Center.



Vincent D. Joseph

Louis J. Ramazotto, PhD has been appointed director of the Institute for Bio-Medical Research at Hackensack University Medical Center.

Monique Mokonchu, MD, assumes responsibilities as medical director of Raritan Bay Medical Center's Birthing Center, in Old Bridge Township.

Pamela Moore takes over as the administrator of The Back Rehab Institute, with locations in Hamilton Township, Cranbury, Margate, and Cherry Hill.



Pamela Moore

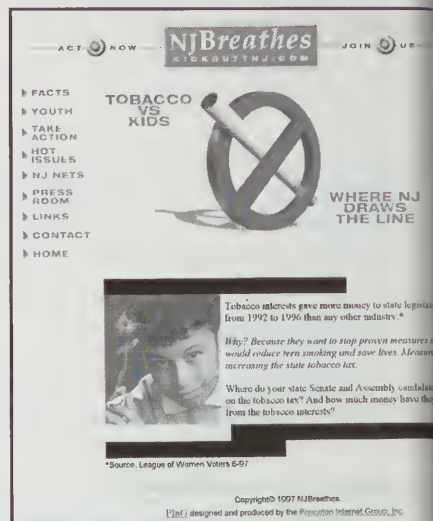
Ronald Siwoff, OD, joins The Gerald E. Fonada, MD, Low Vision Center at Saint Barnabas Medical Center.

New to Monmouth Medical Center are **Maria Roberti, MD**, **Howard N. Guss, DO**, **Andrew Dit-chik, MD**, **Darrell Rigatti, MD**, and **Michael Tavill, MD**.

kickbuttnj.com

Want to win tickets to see a New Jersey Nets basketball game? Click on **www.kickbuttnj.com**, for info about the "Smoking is an Offensive Foul" ticket campaign.

Did you know that tobacco interests gave more money to state legislators from 1992 to 1996 than any other industry? Did you know that tobacco causes more New Jersey deaths each year than AIDS, illegal drug use, violence, and vehicular accidents combined? **www.kickbuttnj.com**, the new web site for New Jersey Breathes (NJB), is more than facts; you're invited to get involved with tobacco control through the most effective way, vocal discourse. The site offers simple, yet effective methods to have your voice heard—like contacting your representatives (the web site's handy "locator map" makes it easy). There's also a section on tobacco tax information and hot issues like legislative activity and current events. NJB is an independent, collective voice for tobacco control convened by MSNJ.



Opening the doors for nursing careers

Nursing was the topic of discussion for a group of juniors and seniors from Trenton High School at the workshop, "**Career Information Workshop on Nursing**." Nurses from various specialties and levels of experience shared their nursing experiences with the students. Speakers included Kathleen McDondald, MSN, RN; Miriam Cohen, MSN, RN; and MaryIn Inverso, RN. In addition, a student was selected to intern at the Institute for Nursing. The workshop was developed by the Institute for Nursing with a grant from CoreStates Bank.



Students from Trenton High School enjoy a day with nurses at Career Information Workshop on Nursing.

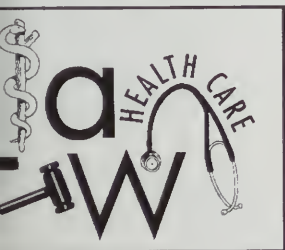
Classified ads go live

The Medical Society of New Jersey (MSNJ) web site, www.msnj.org, now features classified ads. Career openings for physicians and health care professionals, medical equipment for sale, real estate (home and office), and offices to share are some of the listings. Rates for classified ads start at under \$50. Call MSNJ (609/896-1766) to place a classified ad.



Law from A to Z

You'll find a plethora of legal information on the Internet. The search engine, Findlaw (www.findlaw.com/) will point you in the direction of endless legal resources. More legal info is available at LawSource, Inc. (www.lawsources.com/). Search out New Jersey law at the New Jersey State Legislature (www.njleg.state.nj.us/html/njleg.htm). Find



a lawyer or law firm at West's Legal Directory (www.wld.com/). Other useful sites are the American Bar Association (www.abanet.org/)

and Legal Ethics (www.legalethics.com/). For details on Garden State health- and medical-related bills and legislation, check out MSNJ's site (www.msnj.org).

Law on the Net (second edition), by James Evans, highlights existing and new sites, law-related e-mail mailing lists, and legal news-groups. Plus *Law on the Net* comes with a CD-ROM. The book is available from Nolo Press, 950 Parker Street, Berkeley, CA 94710, 510/549-1976.

Lefties take the lead

Left-handed people constantly have to make adaptations to fit into a right-handed society. The standard computer keyboard is made for the 89 percent of computer users who are right-handed. The Internet has a place in cyberspace for those with left-hand dominance. At Lorin's Left-handedness Site (<http://www.arts.uwaterloo.ca/~ljelias>) choose from topics including myths, terms, prevalence, and genetics. Or cruise the ranks of national figures, including Alexander the Great, Ronald Reagan, and Michelangelo who are lefties.

Bookmarks

www.health-line.org/

Looking for straightforward information about health insurance? The not-for-profit Life and Health Insurance Foundation for Education has answers.

www.nj.com

Get the latest from New Jersey Online about our state—entertainment, news, sports, weather, and much more.



www.modernmedicine.com

Managed Healthcare provides practical info about health care costs and quality under managed care.

www.intrack.com/intranet/

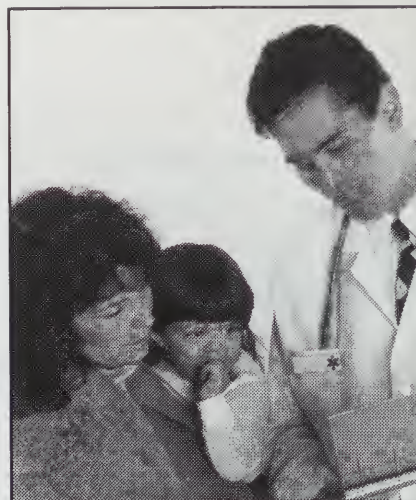
Confused about intranets? Get intranet help at the Complete Intranet Resource.

www.paperchase.com

This interactive biomedical database allows the user to search references and abstracts from thousands of medical journals.

what if[®]

you could choose a health plan that meets all your needs and fits your budget?



You can with the Medical Society of New Jersey's endorsed health carrier of choice. . .



**BlueCross BlueShield
of New Jersey**

If you're an individual or have a family to support, choose from:

- *HMO Blue*[®]
- *HMO Blue*[®] Prime
- Traditional Plans A, B, C, D, and E
- Basic BlueSM (Plan A)
- And our new **M\$A Blue**SM plan with its tax advantages!

If you run a small business, choose from:

- *HMO Blue*[®]
- *HMO Blue*[®] Prime
- Blue SelectSM
- Blue Choice[®]
- Blue Choice[®] Prime
- Traditional Plans A, B, C, D, and E
- And our new **M\$A Blue**SM plan with tax advantages for employers and employees!

OR customize one plan for your company's specific business needs by combining as many as three of these plans. All offer attractive benefits. . . **All offer a 1-year rate guarantee upon enrollment!**



**BlueCross BlueShield
of New Jersey**



**INDIVIDUAL &
SMALL EMPLOYER
DIVISION**

Ask us for a free
copy of the SEH
Buyer's Guide.

Call your Blue Cross and Blue Shield of New Jersey



Sales Representative

JENNIFER ALTOBELLI

1-908-493-8808

® and SM Registered Marks and Service Marks of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans. Blue Cross and Blue Shield of New Jersey and HMO Blue are Independent Licensees of the Blue Cross and Blue Shield Association. HMO Blue is a subsidiary of Blue Cross and Blue Shield of New Jersey.

The problem with aging

The growth of the elderly population in the United States poses severe social, political, and health problems. As this growth continues, more and more individuals will encounter chronic illnesses or physical limitations. In the September 1997 issue of *New Jersey MEDICINE*, Carol J. Kientz noted that home care is the growth market for health care. She ascribes that growth to several factors: the aforementioned increasing numbers of the elderly and disabled; the demand for cost-cutting and reduction of stays in institutions; and advanced technologies, many of them portable enough to allow home treatments.

The home health care agencies in New Jersey have responded to these increased needs in new and innovative ways, including advanced nursing techniques, enlarged rehabilitation therapies of various types, HIV care, preventive health activities, and expanded hospice services.

Unhappily, despite the increasing need for these home health care programs, the federal budget balancing and the proposed revisions and cutbacks in Medicare mitigate against the continuation of this type of care, let alone for its expansion.

Medicare must change. Many have felt that the last large fee-for-service plan was an expensive white elephant. The American Medical Association proposed giving the elderly the same choices enjoyed by federal

employees: traditional fee-for-service versus a variety of managed care plans.

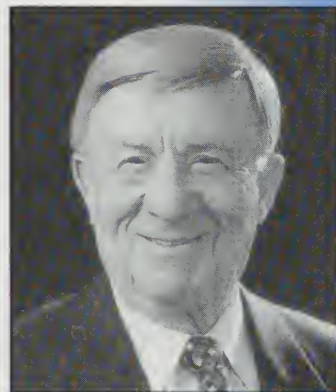
President Clinton then proposed reductions in payments to physicians, managed care organizations (MCOs), institutions, and other providers of care. The administration also justified some of its reductions to MCOs by asserting that they treated a disproportionate number of healthy patients, an accusation

vociferously denied. And payments for home health care would be shifted from the hospital trust fund to a separate one supported by general welfare.

Congress has had four major approaches to cutting Medicare growth, as Marcia Angell outlined in an editorial in *The New England Journal of Medicine* on July 17, 1997. The first was the Clinton proposal to cut payments. The next was to shift more costs to beneficiaries, by increasing the age of eligibility and by increasing out-of-pocket expenses, including deductibles

and co-payments. The third was the limited use of medical savings accounts, whose effects have yet to be evaluated. Finally, "the one considered to hold the most promise" was, as the President suggested, to shift from fee-for-service to managed care.

Angell's editorial also made reference to another article in the same issue, which docu-



Howard D. Slobodien, MD

With a growing elderly population, Medicare must change. Medicare needs revision. It is time for our legislators to act responsibly.

Washington is a city of Southern efficiency and Northern charm.

John F. Kennedy, *Portrait of a President*, 1962

Growing old's like being increasingly penalized for a crime you haven't committed.

Anthony Powell, *Temporary Kings*, 1973

mented how Florida HMO Medicare plans were manipulating the system, by enrolling healthier patients who needed fewer services—just as the Clinton administration had suggested earlier in the year.

At the same time that the Angell editorial appeared, federal health officials announced their decision to proceed with investigations into potentially fraudulent Medicare claims submitted by leading teaching hospitals, two of which had to repay millions in reimbursements and fines.

Then the General Accounting Office (GAO), the congressional auditing body, announced it had found “widespread fraud, overcharges, and substandard care in the medical services provided to frail homebound elderly people under Medicare,” as reported in *The New York Times* on July 27, 1997. The GAO “said that almost any business could be certified as a home health agency, with little or no experience, and that hardly any were expelled from the booming, highly profitable field.” Separately, the inspector general of the Department of Health and Human Services (DHHS) estimated that more than one-third of Medicare payments to home health agencies in some places were not warranted. A week later, a large home health care fraud ring was uncovered in Miami, Florida.

The American Association of Retired Persons (AARP) published an interview of Malcolm Sparrow, lecturer at Harvard's Kennedy School of Government on its web site in August 1997. Sparrow, a former British detective with degrees in mathematics and public health, spent years studying fraud in business industries. After meeting with Janet Reno, who said, “We desperately need help [with fraud] in health care,” he began investigating, which led to the publication of *License*

to Steal: Why Fraud Plagues America's Health Care System. He estimated that between 20 and 35 percent of the Medicare budget—\$38 to \$63 billion—was lost to fraud, and that we need much more sophisticated controls. Otherwise, he wrote, “We can cut costs . . . the indiscriminate way [by] slashing reimbursement rates [and] denying benefits and treatments to people who genuinely need them.” June Gibbs Brown, the DHHS inspector general, felt his estimate was too high, but conceded that 14 percent may be lost to waste, fraud, and abuse.

Horace B. Deets of the AARP has advocated national standards for managed care plans, particularly those involving Medicare. Kientz and the New Jersey Home Health Assembly agree with the need for federal and state efforts to root out abuse in the Medicare system, but she has pointed out most clearly how closely her organization has worked with our legislators to safeguard the quality of care being delivered. Unfortunately, at the time of this writing, congressional leaders seem loathe to impose meaningful controls to safeguard the quality, and the value, of care being given via managed care.

The problem will intensify. The White House, having seen Medicare in place and having extended coverage to millions of children, now is considering aid for the “near elderly,” the three million between the ages of 55 and 65 years.

As Kientz advised, there are increasing needs for home care delivery systems, so we cannot afford to waste monies intended for care on entrepreneurial chiselers. Nor can we give short shrift to those in need. As Jack Nicklaus said, “The older you get the stronger the wind gets—and it's always in your face.” Medicare needs revision; it's time for our national legislators to act responsibly.

MSNJ MAKES THE MARK: THE TOP 20 WINS OF 1997

Carl Restivo, Jr, MD

Dr. Restivo is president of the Medical Society of New Jersey (MSNJ).

For over 225 years, MSNJ has kept up with the steady—and sometimes accelerated—pace of change in the health care field. This rapid change is especially visual today, as health care issues regularly rise and fall. And MSNJ has modified and molded its focus to meet the new concerns and needs of the medical profession in the Garden State. MSNJ has been continuously advocating for physicians, medicine, and the public.

MSNJ secured major achievements in 1997 for its members—and for the medical profession and the public. I am especially proud that MSNJ is at the forefront of protecting health care and medicine for its members, the public, and the health care community. Here is a listing of our top 20 accomplishments for 1997:

1. Steered the Health Care Quality Act.
2. Won the fight for the nation's toughest HMO regulations.
3. Initiated action that led to an agreement with the commis-

sioner of Health and Senior Services by all members of the New Jersey HMO Association to pay all clean claims within 60 days or else pay 10 percent interest.

4. Obtained the end of the malpractice reinsurance surcharge on all premiums.

5. Convinced the state Attorney General to postpone and soften implementation of the new Uniform Prescription Blank legislation.

6. Established a web site, www.msnj.org, with the Physician Finder—a directory of MSNJ members.

7. Reviewed proposed HMO contracts for all members upon request.

8. Was the only state medical society to submit its own brief to the U.S. Supreme Court in the physician-assisted suicide cases.

9. Led the state in efforts to increase the tobacco tax to reduce smoking by children.

10. Created an International Medical Graduate Section.

11. Helped change the state's charity care program to a new managed care format.

12. Convened an Expert Advisory Panel that issued a report on intact dilatation and extraction.

13. Sponsored an economic study showing that New Jersey physicians contributed \$4 billion to the state's economy.

14. Developed and released a landmark protocol allowing do-not-resuscitate orders for terminally ill patients outside of hospitals.

15. Supported tough guidelines for managed care medical directors by the state Board of Medical Examiners, and obtained an extension for medical license renewals.

16. Beat back efforts to reduce physician reimbursement under the PIP program of automobile insurance.


17. Revised the comprehensive policy on HIV/AIDS.

18. Offered the newly formed Legal Consultant Network to members.

19. Increased medical student loan disbursements.

20. Reviewed complaints against members submitted to the MSNJ Judicial Council.





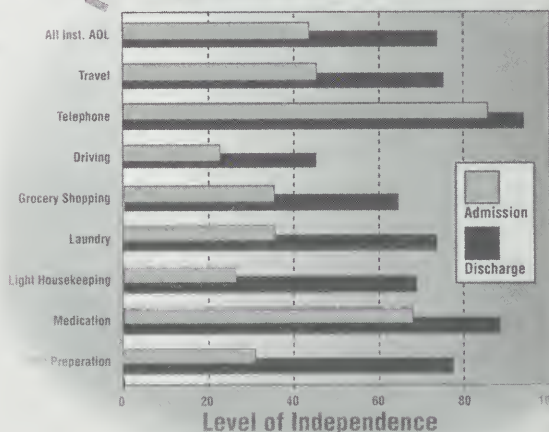
Superior Sub-Acute Care Means Faster Recovery...That's the Bottom Line!

In a time when managed care has the healthcare industry re-evaluating everything it does, New Jersey Postacute Network has remained focused on a single, time-tested concept that benefits everyone: *superior care*. By providing better care in a skilled nursing environment, NJPAN can provide major cost savings to managed care organizations by reducing the duration of acute, in-patient care and achieving faster recovery. NJPAN offers case managers comprehensive outcome reporting that keeps them completely informed on the patient's progress, resource utilization and cost factors. We also provide numerous specialty services like ventilator management, traumatic brain injury rehab, pediatrics, dialysis and others which make it easy to place traditionally hard to place patients. The final result: patients gain a greater level of independence and return to their family or occupation faster. **NJPAN - Everyone wins!**

For more information or to make a referral
please call NJ PAN at
800-356-5726

623 Eagle Rock Avenue • Suite #6 • West Orange, NJ 07052
973-731-4774 • Fax: 973-731-8895

Instrumental ADL - All Patients



Facilities accredited by:



Joint Commission
on Accreditation of Healthcare Organizations*

NJPAN
NEW JERSEY POSTACUTE NETWORK

NJPAN SUBACUTE PROVIDERS

Bey Lea Care Center • Inglenoor Care Center • Laurelton Care Center • Forest Manor Health Care Center • Whiting Healthcare Center • Silver Care Center
Hamilton Park Health Care Center • Mediplex of Oradell • Mediplex Subacute Center • Meadow View Nursing & Respiratory Care Center
Lakeview Subacute Care Center • STAR Program at Linwood Convalescent Center • Clark Nursing and Rehabilitation Center • Broadway House for Continuing
Care • Voorhees Pediatric Facility • The Neuro-Med Brain Injury Rehabilitation Center and King James of Somerset • Hunterdon Care Center

* some facilities pending accreditation

Bill Berlin, PhD

INTERVIEW WITH LEAH Z. ZISKIN, MD, MPH

Dr. Ziskin is the deputy commissioner with the New Jersey Department of Health and Senior Services. She was the 1995 honoree of the AMA's Nathan Davis Award, given to a state government leader for an outstanding career in public service. A member of the Medical Society of New Jersey (MSNJ), Ziskin served as vice-chair for the MSNJ Committee on Women in Medicine.

Q. What do you consider to be the major accomplishments in the area of public health in New Jersey over the last five years?

A. One important thing we've accomplished is to use technology, and especially computerization, as a tool for information and monitoring. The electronic birth certificate program is a major example of this, along with the AIDS and HIV registries.

Q. Why is the electronic birth certificate program important?

A. It's our first major vital statistic and provides a baseline for every baby born in the state. Also, we add births that may occur out of the state but are born to mothers who are official residents. The electronic birth certificates give us a real time idea of how many births there are in the state and where they are occurring. One of the practical uses we made out of it was to evaluate how our length-of-stay statute was working. We also are using the electronic birth certificate to do a patient-mother satisfaction survey on the length-of-stay law, and we will use it for other kinds of case control and epidemiological studies.

Q. Is it being used in coordination with the immunization registry?

A. Several things happen to babies in the hospital. Newborns are treated for inborn errors of metabolism, largely to prevent mental retardation but also to protect infants from some infectious

diseases, such as sickle cell disease. If sickle cell is detected, then the baby is put on an antibiotic, because sickle cell makes a child very vulnerable to early infections. We also immunize—it's the first immunization against hepatitis B. Once we get a statewide immunization registry, we will be able to track children and make sure that their medical home or their pediatric home has a record of immunizations. Then, as they see a physician or pediatrician and immunizations are given, they will be put into the registry.

Q. What challenges do you see in this area?

A. With all of the electronic tools, and especially the registries, I think confidentiality emerges as a major issue. I am a believer in technology and I think that we will find a way to keep things confidential that should be confidential. Certainly the way we use registries are with non-identifiers and congregate

numbers, and we make analyses based on population.

The other challenge I see with this technology is that people still need a personal approach. I think mothers and fathers value their children's birth certificates and don't want to think of it in a machine. There still is a need for a real certificate that we can hold in our hands and keep for a lifetime. We have to be careful not to get so electronic that we lose sight of that.

Q. What about the confidentiality issue in regard to the AIDS registry?

A. The AIDS registry is one of the very confidential registries and we treat it with utmost care. I'm proud that New Jersey had one of the first HIV registries by person—and this one is by identifier, and we have not had any breach in the identification of cases reported to us. We consider that a very sacred trust: the confidentiality of both the HIV and the AIDS registries.

Q. Should we be doing more in the area of AIDS in

terms of public health measures?

A. Both in the public press and in the public health and medical journals there's been a lot more written about treating AIDS through a "public health model." We are very aware of the discrimination that still



Leah Z. Ziskin, MD, MPH

exists, in housing, in jobs, and even in some treatment facilities, because of a lack of knowledge, fear, bias, or prejudice. Whatever the reason, I think it's real, and the HIV or AIDS persons afflicted are aware of this and many feel the need to hide their disease. I'd like to find them as early as we could. But I'm not

ready to support mandatory testing because I think we have been fairly successful in getting the word out so that people with the disease can get the treatment or the support needed.

Q. Do you worry about picking up a newspaper and seeing a story like the one about the man in New York State who may have passed on HIV to 20 or 25 people?

A. We checked our registries in a confidential way and assured ourselves that not one of this man's contacts had a New Jersey address. In terms of public health, we do have a partner notification system in place along with HIV reporting. We interview

people who come to our attention to find out if they understand how they may have contracted the disease and then try to inform sex partners. This is very delicate, but it is a tool that we learned from the sexually transmitted disease folks and we do it in a very confidential manner.

Q. Do you see more compatibility today between the

With all the electronic tools, especially the registries, confidentiality emerges as a major issue. I know we will find a way to keep things confidential that should be confidential.

medical and public health professions in respect to disease prevention?

A. I certainly do. But in the old days, not too long ago, those of us in public health and preventive medicine seemed to be the advocates for prevention and traditional medicine was the advocate for cure. So it has been gratifying that we are now getting more and more of traditional medicine coming over and saying, "You know this prevention message isn't so bad; there may well be something to it."

Q. What form do you see this taking?

A. We are seeing it in private medicine, in group practice settings, in hospitals, and with managed care organizations holding classes in disease prevention. Tobacco control is a major area and David Kessler is a real hero for defining tobacco addiction as a pediatric disease. I think the good part is that we are starting to see physicians and other health care providers talk

the language that public health and preventive medicine have spoken for years, and I think the challenge now is getting to the public. We still have all the surveys telling us that



Dr. Ziskin addresses an audience of MSNJ members.

Americans are overweight. We still are selling drugs to help people lose weight and just as with tobacco, a drug alone isn't the way you do it. You have to get to the psyche; you have to impact behavioral change to have a long-lasting meaningful effect.

Q. I've heard many physicians, particularly those in urban areas, refer to violence

as a public health issue. Do you agree?

A. I personally believe violence is a public health issue. In the past the attitude was, "that belongs to law

enforcement." Many emergency physicians are appalled by the human and societal costs of this violence. We had a project through which we educated family members of people who wound up in emergency rooms, especially teenagers, about preventing this kind of violence. We've had programs in the schools, teaching children how to

confront one another verbally, so that it does not reach the physical level. We are finding more and more that it's important to get to adolescents. We used to think that high school was the age. Now we are trying to focus on middle schools in terms of AIDS, drugs, tobacco, alcohol, the harder drugs, and violence.



Excel Business Park

501 Prospect Street

Unit 96

Lakewood, NJ 08701

Phone: 732•886•0600

Fax: 732•886•0911

"The overall effect is total customer satisfaction."

- Medical/Dental Cabinetry
- Nurses Stations
- Reception Desks
- Nourishment Centers
- Medical/Dental Procedure Carts
- Computer Desks
- Monitor Cabinets
- Chart Racks
- Corian® Solid Surfacing Certified Fabricator #C-5112
- Space Planning/Layout



Druker, Rahl & Fein

Business Consultants
Certified Public Accountants

We have your prescription to profitability

We're Druker, Rahl and Fein, the accountants and advisors
to physicians and health care providers.

...Managed Care..Government Regulations

..the industry is changing..quickly.

How will these changes affect your practice?

You have questions and you need answers.

Our medical services experts will assist you
in developing a strategy to
succeed in this dynamic environment.

Leaders in:

Cost Accounting • Strategic Planning • Group Practice Formation • Tax
Managed Care Analysis • Practice Valuations • Practice Management

200 Canal Pointe Boulevard • Princeton, NJ 08540-5998 • 609-243-9700 • FAX 609-243-9799

Contact Robert J. Rahl, CPA

How managed care affects nursing

David M. Price, MDiv, PhD

Patricia A. Murphy, PhD, RN, CS

Drs. Price and Murphy are clinical ethicists at Saint Barnabas Medical Center and at Newark Beth Israel Medical Center, respectively. Dr. Price is on the faculty at UMDNJ-New Jersey Medical School. Dr. Murphy is immediate past-president of the New Jersey State Nurses Association and is on the Board of Directors of the American Nurses Association.

Organized nursing seems less threatened by managed care than organized medicine. One might say the predominant attitude is open, but wary.

The American Nurses Association (ANA) and other state nursing associations have published position papers outlining the criteria by which they think this massive exercise in social engineering should be evaluated. In general, these formal pronouncements look

remarkably like the efforts of medical societies. Nursing's ethical bottom line is allegiance to the Hippocratic ideal: the patient's well-being comes first.

Nursing and medicine diverge somewhat as one gets beyond the generalities. This is not surprising, given the complementary training, theoretical orientation, clinical perspectives, and social history of nurses and physicians. Nurses are likely to have a somewhat different slant than physicians on several areas of concern: best practice protocols, opportunities for advanced practice nurses, jobs shifts from acute to home care, rising acuity levels, rightsizing, and work redesign.

Best practice protocols. Managed care has stimulated and will continue to stimulate the development, promulgation, and promotion of practice guidelines. Increasingly, practitioners who depart from established "best practices" must be prepared to justify decisions. This phenomenon, by itself, is the occasion for many unprintable outbursts and much dyspepsia among physi-

cians, especially among older, primary care physicians in solo practice who may have had little experience since residency in accounting to others for their day-to-day behavior.

By contrast, best practice protocols are not new to nurses. Most nurses always have worked in organized systems of care in which published standards define good practice, new developments are systematically disseminated, and interprofessional and intraprofessional cross-checking are accepted ways of life. Of course, all nurses find some of this onerous and can share anecdotes of bureaucratic excess that ended up impeding good patient care. But nurses tend to accept the necessity and appreciate the virtues of clinical accountability to well-established standards of care. Their different social history makes nurses more familiar than their physician counterparts with both the best and the worst of clinical practice guidelines. On the whole, nurses are more sanguine about managed care-generated rules, in part, because

they have seen so much clearly indefensible clinical behavior that has gone unchallenged by local standard-setters. It is reassuring to nurses that managed care practice guidelines are apt to be research based, outcome oriented, up-to-date, and peer reviewed.

Opportunities for advanced practice nurses. Organized medicine and organized nursing have sharply divergent attitudes about increasing the regulatory and market opportunities for nurse practitioners and clinical nurse specialists. On its face, the policy disagreement may appear to be merely a mutually self-interested turf battle between two rival guilds. It ought to be more than that.

The rapid expansion of managed care, with its shift of power away from the traditional professional groups and local institutions to larger market forces and business interests, may shape the future of advanced practice nursing more than anything that the organized professions do. Managed care companies have an economic incentive to test the nursing community's contention that advanced practice nurses can provide (and, in some places, have provided) much primary care as well as or better than physicians at a lower cost. If that claim can be verified empirically, advanced practice nursing will grow; if not, advanced practice nursing will remain limited.

"Win or lose," both nursing and medicine should be satisfied with an outcome based on evidence about optimal care at optimal cost. The extent to which that sounds idealistic is the extent to which we have slipped from our finest traditions of patient-centered service.

Jobs shift to home care. The advent of managed care has accelerated the emptying of hospitals. Naturally, this development has had dramatic impact on the largest category of acute care hospital workers. As the proportion of nurses working in hospitals con-

tinues to shrink, less adaptive nurses assume that their careers are in jeopardy. Others are demonstrating the kind of flexibility that is characteristic of the best clinicians. Some displaced nurses have had very happy surprises as they moved into long-term care or home care. One friend, in her early 60s, loves her new career in a nursing home, stimulated by the unfamiliar territory and enjoying the appreciation of her new colleagues for hospital-honed skills now required in long-term care. Nurses moving into home care settings from medically dominated acute care settings can discover a rejuvenation of professional spirit as they take on more central roles in overall management of care. Recent emphasis on improved end-of-life care will further enhance the roles of home care and long-term care nurses.

Rising acuity levels. The average patient in all settings is sicker and undergoing more complicated treatment than at any time in history. Hospitals are becoming more and more like large intensive care units as recovering patients are pushed out earlier and more surgery is performed in nonhospital settings. In the meantime, patients who require some very complicated treatment receive high-tech interventions at home. What this means is that, regardless of setting, professional nurses typically have more responsibility and require ever higher levels of knowledge and skill. Managed care, with its economic imperative to contain costs in the face of continuing technological development, drives this phenomenon.

The same forces affect physicians, except that the rate of change is more quickly felt in nursing because professional nurses are more tightly tied into institutional mechanisms where innovation diffuses more rapidly than in the loosely organized world of office-based practice.

Rightsizing. The economic imperative for every institution in a market-driven system is to optimize

the balance between output and input, i.e. to increase productivity. This management challenge involves countless large and small decisions that, in turn, are based on educated guesses about what one should do to achieve one's goals. Downsizing is easy; rightsizing is a different story, involving the highest and most complex of all human capacities: evaluation. Hence, making economic decisions is much like making ethical decisions. When the pressures for rightsizing are urgent (as when a poorly managed hospital must play catch up urgently or go under), there can be little margin for anything but essential activities. The high-stakes challenge is to discern what activities are truly essential. Here is where good people can and will disagree. Here, too, is opportunity for creative problem solving, vision, and leadership on the part of nurses, as much as anyone else.

Nurses and others need to resist the seduction of quick, but short-sighted results. Smart rightsizers distinguish between urgency and importance, between cheap gains and solid improvement, between what looks good and real quality. They know that there can be no lasting quality without financial strength and no lasting financial strength without quality.

Work redesign. Foremost among efforts to increase nursing productivity is the assignment of some nursing tasks to paraprofessionals. To do this properly entails careful analysis of nursing functions to determine exactly which activities may safely, appropriately, and feasibly be carried out by less expensive personnel.

An implication is that virtually every nurse becomes a supervisor. Managerial skills are not reserved for nurse managers but are needed at the staff nurse level. While there is nothing wrong with this development, it may be happening faster than

the tens of thousands of staff nurses can be equipped with the requisite skills or have these competencies certified. Much is being instituted wholesale without prudent pilot testing. While some protests have been too shrill, this is genuinely worrisome.

Management of unlicensed assistive personnel entails challenges beyond what we mean by merely managerial skills. There is a dimension of judgment involved in the delegation of tasks for which the professional nurse retains moral and legal responsibility. The concern becomes clearest by reference to the ANA's code of ethics: "The nurse exercises informed judgment and uses individual competence and qualifications as criteria in seeking consultation, accepting responsibilities, and delegating nursing activities to others." This is a rather demanding and uncompromising requirement. It is unclear how a nurse prudently and in good conscience can delegate tasks in many fast-paced hospital situations, particularly those involving unfamiliar rotations, agency personnel, or "floats."

Conclusion. Even though self-consciously designed to present a distinctive nursing perspective, we allude to a number of ways in which modern market forces are narrowing traditional gaps between the practice circumstances of nurses and physicians. Even as more physicians work as salaried employees, more nurses work independently. Concomitantly, differences in compensation and educational background are becoming less pronounced. In conjunction with other systemic forces, managed care seems to be bringing medicine and nursing closer together with respect to practice patterns, sociopolitical prerogatives, economic interests, and scope of responsibility. Thus, a lasting effect of managed care may turn out to be a convergence of perspectives between nurses and physicians with respect to all manner of issues, including managed care.

NJM

Practicing medicine
= good

Practicing running
a business
≠ good

*Practice management and
practice efficiency solutions
from professionals with
hands-on experience*

WITHUM, SMITH & BROWN

Certified Public Accountants & Consultants

Health Services Department

100 Overlook Center

Princeton, NJ 08540

609-520-1188

<http://www.withum.com>

Offices in New Jersey and Pennsylvania



MEMBER NEXIA INTERNATIONAL
A WORLDWIDE NETWORK OF
INDEPENDENT ACCOUNTING FIRMS



I HEAL DOCTOR'S OFFICES. TELL ME WHERE IT HURTS!



Mary Ann Hamburger has triumphed as the most comprehensive and efficient single source for medical office set ups and reorganizations. She is an expert in every detail of office administration, from personnel hiring and training, to phone systems, billing and collections, to CPT and ICD updates. Mary Ann is expert in third-party payments, setting fee schedules, and the selling of medical practices. Mary Ann is dependable. She has the contacts, background and practical know-how to set up or improve your office systems.

Your medical practice is a business, and if that business does not run efficiently, it will affect your patient and public relations. You know what you need, but you don't know how to go about it. Call for a whole new approach to medical office practice.

MARY ANN HAMBURGER
A S S O C I A T E S

THE SPECIALIST'S SPECIALIST

74 HUDSON AVE. MAPLEWOOD, N.J. 07040

973-763-7394

MSNJ PHYSICIAN FINDER ON

**MSNJ WEB SITE at
WWW.MSNJ.ORG**

The physician finder is a web site, electronic directory of active MSNJ members.

A place to run for information about MSNJ physicians.

See advertisement on page 67.

DUODENAL PERFORATION: THE LAPAROSCOPIC PERSPECTIVE

*Ibrahim M. Ibrahim, MD
Barry Sussman, MD
Fred Wolodiger, MD
Fred Silvestri, MD*

The authors are affiliated with the Department of Surgery, Section of Laparoscopy, Englewood Hospital and Medical Center.

Diagnostic laparoscopy has proved to be a valuable modality in the diagnosis of intra-abdominal pathology.¹ This especially is important in the setting of acute abdominal pain.^{2,7} Delineation of the etiology of the acute abdomen can be made with a high degree of accuracy. In addition, advanced laparoscopic techniques enable the surgeon to simultaneously treat a host of acute pathological conditions, such as appendicitis, small bowel obstruction, and cholecystitis. Acute duodenal ulcer perforation can be easily diagnosed and treated laparoscopically.^{8,10} We present our experience with the management of acute perforation of duodenal ulcers.

Materials and methods.

One hundred thirty-six exploratory laparoscopies were performed for the clinical diagno-

sis of acute abdomen from 1991 to 1996. Of those, 8 patients were clinically suspected of having duodenal ulcer perforation. All patients presented with a history of sudden onset of severe and increasing abdominal pain. The duration of pain varied from three hours to four days prior to first presentation. Pneumoperitoneum was noted either on plain abdominal films or computed tomography (CT) scans in 7 patients. In 1 patient, the diagnosis was confirmed preoperatively by upper gastrointestinal (GI) gastrografen study. Two patients had significant chronic obstructive pulmonary disease (COPD). The diagnosis of perforated duodenal ulcer was confirmed laparoscopically in 6 of the 8 patients. In the other 2 patients, the diagnoses were acute perforated appendicitis and perforated diverticulitis. All patients with perforated duodenal ulcers were treated laparoscopically with omental patch plication.

Surgical technique. The abdomen is insufflated via an

umbilical port that was used for the introduction of the laparoscope. Two other 5 mm trocars are inserted, one trocar on each side of the abdomen. Appropriate cultures are taken. Obstructing adhesions when present are lysed until the perforated ulcer is clearly visualized.

The ulcer then is sutured with one or two 2-0 silk sutures. The lesser or greater omentum is sutured over the ulcer. The abdomen is thoroughly irrigated with saline with or without antibiotics. Fibrino-purulent material when present is peeled off the bowel and removed. The umbilical trocar site then is closed with absorbable sutures. The patient is placed on nasogastric suction until bowel function returns. Broad spectrum antibiotic coverage is used in all cases.

Results. There was no perioperative morbidity or mortality. Oral alimentation was started as soon as bowel sounds returned. This varied from one day to five days commensurate with the severity of peritonitis,

Added benefits of laparoscopy are diminished incisional pain, better cosmesis, and decreased postoperative adhesions for many patients.

which was related to the delay in patient presentation. Similarly, hospital stay was related to the degree of peritonitis and varied from two to ten days. There were no complications related to laparoscopy. One patient with severe COPD and cardiac disease expired two and one-half months, postoperatively.

Discussion. The widespread use of H₂ blockers and proton pump inhibitors, and the discovery of *H. pylori* have radically changed the long-term management of duodenal ulcer disease. Though most ulcer disease can be cured or controlled medically, there still remain complications such as massive hemorrhage or perforation that demand urgent intervention.¹¹ The natural history of acute duodenal ulcer perforation is varied. There is evidence that 12 percent of perforations seal spontaneously as proved by negative gastroduodenography; these perforations can be treated conservatively.¹² The majority of perforations require intervention to arrest continuous peritoneal soiling and peritonitis. Modern laparoscopic tech-

niques can be easily applied to the management of this serious complication.

Pneumoperitoneum is most commonly due to colonic diverticular perforation or perforated duodenal ulcer. The negative gastroduodenogram may indicate either a sealed perforation of the duodenum or colonic perforation. Laparoscopy can accurately localize the area of perforation in the gastrointestinal tract. The surgeon then may proceed with an appropriately placed incision if he decides to convert to a standard laparotomy. In the two patients not having a perforated ulcer, an accurate diagnosis still was made by laparoscopy. One patient with appendicitis was treated laparoscopically and the other patient with perforated diverticulitis was treated by an appropriately placed incision in the left lower quadrant followed by a Hartman procedure.

The ability to perform adequate peritoneal lavage is another distinct advantage of laparoscopic therapy. Nonoperative management results in intra-abdominal abscesses in 2

to 15 percent of cases.¹² Such lavage can be more thoroughly done laparoscopically as all quadrants can be easily visualized and irrigated. This will diminish the risk of subsequent abscess.

In this minimally invasive approach, the length of hospitalization is determined largely by the extent of the peritonitis. In early peritonitis, the patient can be started on an oral intake within one day and then discharged. In well-established peritonitis, the patient is hospitalized until the peritonitis is resolved.

Other added benefits of laparoscopy are diminished incisional pain, better cosmesis, and decreased postoperative adhesions.

Different minimally invasive methods for closure of perforated duodenal ulcers have been described. Costalat described pulling the ligamentum teres through the perforation by a dormier basket inserted via a gastroscope and held in place for seven days.¹³ Ystgaard used staples to close the perforation.¹⁴ Others described the use of an omental patch with fibrin

sealant.^{9,15} Katkhouda and others advocated suture closure of the ulcer with omental patch.¹⁶ This is the time-honored method that has proved to be successful in open procedures.

Once intracorporeal suturing and knot-tying is mastered, the procedure is straight-forward and can be performed expeditiously.

Conclusion. Perforated duodenal ulcers can be accurately diagnosed and appropriately managed laparoscopically. In addition, a more thorough peritoneal lavage can be performed laparoscopically.

When diagnosed early, patients can be expeditiously discharged. With delayed patient presentation and extensive peritonitis, a more prolonged length of stay can be expected. Though our series is small, it confirms the utility and safety of the laparoscopic approach.

References

1. Nagy A, James D: Diagnostic laparoscopy. *Am J Surg* 157:490-493, 1989.
2. Sundal E, Gyn K, Farhlaender H: Peritoneoscopy in abdominal emergencies. A valuable diagnostic tool. *Endoscopy* 14:97-99, 1982.
3. Reiertsen O, Rosseland AR, Hoivik B, Solheim K: Laparoscopy in patients admitted for acute abdominal pain. *Acta Chir Scand* 151:521-524, 1985.
4. Berci G, Sachier JM, Poz-Partlow M: Emergency laparoscopy. *Am J Surg* 161:332-335, 1991.
5. Graham A, Henley C, Mobley J: Laparoscopic evaluation of acute abdominal pain. *J Lapend Surg* 1:165-168, 1991.
6. Paterson-Brown S: Emergency laparoscopic surgery. *Br J Surg* 8:279-283, 1993.
7. Scott HJ, Rosin RO: The influence of diagnostic and therapeutic laparoscopy on patients presenting with an acute abdomen. *J Roy Soc Med* 86:699-701, 1993.
8. Vereecken L: Laparoscopic treatment of perforated gastroduodenal ulcer. *Surg Endosc* 7:123, No. 183 abstract, 1993.
9. Mouret P, Francois Y, Vignal J, et al.: Laparoscopic treatment of perforated peptic ulcer. *Br J Surg* 77:1006, 1990.
10. Johansson B, Hallerback B, Glise H, Hohnsson E: Laparoscopic suture closure of perforated peptic ulcer. A non-randomized comparison with open surgery. *Surg Endosc* 10:656-658, 1996.
11. Bardhan KD, et al.: Changing pattern of admissions and operations for duodenal ulcer. *Br J Surg* 76:230-236, 1989.
12. Berne TV, Donovan AJ: Nonoperative treatment of perforated duodenal ulcer. *Arch Surg* 124:830-832, 1989.
13. Costalat FDG, Noel P, Aliquir Y, Vernhet J: Coelioscopic treatment of perforated gastroduodenal ulcer using the ligamentum teres hepatis. *Surg Endosc* 5:154-155, 1991.
14. Ystgaard B, Marvik R, Thorensen JE: Laparoscopic treatment of perforated ulcer disease. *Surg Endosc* 8:947, 1994.
15. Tate JJT, Dawson JW, Lau WY, Li AKC: Sutureless laparoscopic treatment of perforated duodenal ulcer. *Br J Surg* 80:235, 1993.
16. Sunderland GT, et al.: Laparoscopic repair of perforated peptic ulcer. *Br J Surg* 79:785, 1992.

When professional health law counsel is called for,
call the firm the experts are calling.



For years health care providers and businesses have been calling Theodosia A. Tamborlane P.C. when they needed accurate information, insightful commentary and practical advice. That's because Theodosia A. Tamborlane P.C. successfully navigates through the maze of government activity at both state and federal levels every day.

Today physicians, hospitals, nursing homes, assisted living, ambulatory care

facilities, home health care agencies and other providers turn to this firm for legal services including managed care contracting and corporate compliance plans. It's little wonder why leading health law publications and the nation's most prestigious legal, medical and business associations keep calling Theodosia A. Tamborlane P.C. to keep their members up to date. When you need professional legal counsel select the firm that knows the issues ...

Theodosia A. Tamborlane, P.C.



THEODOSIA A. TAMBORLANE, P.C.

COUNSELORS AT LAW

1044 ROUTE 22 WEST, MOUNTAINSIDE, NEW JERSEY 07092

908-789-7977

Member, American Medical Association Doctors Advisory Network

Charter Member, American Association of Physician-Hospital Organizations-Integrated Healthcare Delivery Systems

Bill Berlin, PhD

GETTING TO THE HEART OF THE PROBLEM: WOMEN AND CHOLESTEROL

For years, the relationship between women and heart disease was stuck in the Dark Ages, overlooked by researchers, downplayed by diagnosticians, and often ignored by women themselves. Coronary artery disease, the most frequent cause of death among women in this country, often took a back seat to other illnesses, such as cancer and various gynecological conditions.

Even now, many women are unaware of heart disease risk. A survey by the American Heart Association (AHA) released in fall 1997 found that only 8 percent of women in the United States see heart disease and stroke as major health threats. The AHA survey, focusing on more than 1,000 women over the age of 25, indicated that 61 percent viewed cancer as their most significant health risk, compared with 7 percent who identified heart disease and 1 percent who cited stroke.

"We've developed some amazing blind spots about

coronary artery disease," Dr. John C. LaRosa, chancellor of Tulane University Medical Center, told Reuters Health in April 1997. "It just hasn't reached the same level of consciousness as breast cancer, which is much more visible and much more dramatic, and has much more of an emotional content to it."

The facts, of course, tell a far different story. In 1995, more than 500,000 women died of cardiovascular diseases, twice



Trina Frankel, MD

the number that died from all forms of cancer combined. Heart disease and stroke have killed more women than men every year since 1984. Heart disease kills more women each year than the next 16 causes of death combined, including cancer, pneumonia, diabetes, lung

disease, accidents, and AIDS. A postmenopausal woman has a 31 percent lifetime mortality risk from coronary heart disease (CHD), versus a 2.8 percent mortality risk from hip fracture or breast cancer.

Research suggests that the medical treatment of women has not kept pace with the growing knowledge of their risk. One recent study found that women with angina received less invasive and non-invasive diagnostic testing than their male counterparts, despite having more severe symptoms at baseline. Even after controlling for baseline differences, researchers found that women had inferior clinical results after one year when compared to men.

Cholesterol, long considered to be a significant risk factor for CHD, also has gotten short shrift in the treatment room. Two studies have concluded that only 10 to 25 percent of women with heart disease have been treated with cholesterol-lowering medications. A study, published in *The Journal of the American Medical Association* in April 1997, suggested that many women were not taking these drugs at proper dosage levels.

In New Jersey, however, the situation may be changing. A number of practitioners report that women patients increasingly are aware of cardiac risk factors. Trina Frankel, MD, who has an internal medicine practice in Millburn, sees a cross-section of women from different social and economic backgrounds, and most are fairly knowledgeable about the dangers of heart disease. "With most of my patients," she says, "if I tell them that their cholesterol is normal, that's not enough. They want to know the numbers."

Jacob Haft, MD, chief of cardiology at St. Michael's Medical Center in Newark, also believes that both women and clinicians are becoming more aware of the problem. "Because we were not used to seeing women as being at risk for CHD, they have not been treated as vigorously as men," he says. "But I think that's changing."

One problem has been that not enough women have been going for basic examinations. Many women do not have a general internist; many women use their gynecologist as a primary care physician. Thus, routine care has involved a regular visit for an examination of the reproductive system, and perhaps little else. Some younger women have blood work done during pregnancy but may

have minimal followup in ensuing years.

In fact, most experts today recommend a baseline cholesterol test for women in their early 20s, followed by regular monitoring. In this regard, the current shift to managed care, with its emphasis on primary care gatekeepers, may yield positive results with more women introduced to general examinations and blood work, if covered by the insurance companies.

High cholesterol, or hypercholesterolemia, tends to advance as women mature, becoming more common past the age of 50, and especially prevalent following menopause. One study found that more than one out of three women between the ages of 50 and 59 had serum cholesterol levels higher than 240 mg/dL. For women who were 60 years and older, more than 40 percent had cholesterol at these levels.

Women generally have higher levels of high density lipoprotein (HDL) cholesterol than men, with a slight decrease occurring at menopause. Low density lipoprotein (LDL) cholesterol, on the other hand, tends to rise

steadily during and after menopause, and in later years often exceeds those in men. This pattern tends to parallel the general risk of CHD in the genders: a woman's risk of heart disease is greater after the age of 60, while a man's risk increases significantly after 50.

In postmenopausal women, estrogen replacement therapy has been associated with both lower cholesterol and reduced risk of CHD. Although the reason for estrogen's positive influence on cholesterol remains unclear, the results are not. One study concluded that women taking estrogen experi-

enced a 13 percent decline in plasma LDL, the so-called "bad" cholesterol, and a 23 percent increase in plasma HDL, the "good" cholesterol. Estrogen appears to reduce total cholesterol levels very

rapidly—in less than two weeks—while HDL levels increase more gradually over time, suggesting that different mechanisms may be at work.

Likewise, most studies of postmenopausal women taking estrogen replacement therapy have indicated a 40 to 50 percent lower risk of heart attacks



Jacob Haft, MD

compared to women not taking the hormone. But estrogen replacement therapy is not for everyone, and is especially uncertain for women with a mother or sister who had breast cancer. Even without this risk factor, some women and physicians are reluctant to embrace estrogen therapy, preferring to "wait and see" the results of ongoing research.

The first line of defense against high cholesterol involves changes in personal behavior, particularly weight loss and diet modification. A low-fat diet, exercise, and weight reduction can lead to significant drops in cholesterol levels. Conversely, higher LDL levels are associated with higher body mass, and a 10 percent increase in weight has been associated with a rise of 12 mg/dL in cholesterol. A 20-pound weight gain doubles the risk of CHD. And obesity appears to triple the chance of diabetes mellitus, which is a stronger risk factor for heart disease in women than in men.

If attempts at weight loss prove unsuccessful, and they usually do, many physicians are recommending statin cholesterol-lowering medications. Frankel, for example, encourages patients to take the statins if they have high cholesterol along with such risk factors as obesity, smoking, or diabetes. Still, many patients need to be

convinced. "A lot of people," she says, "are happy to take 'natural' medicines that are not FDA-approved before taking a medicine that we know works and has been scientifically tested."

The research suggests that women with CHD may benefit more than men from cholesterol-lowering medication. In one study, 576 women with CHD took either pravastatin or placebo daily for five years. Study participants had cholesterol levels of 240 mg/dL or less. The women who took pravastatin experienced a significant decrease in fatal heart attacks, non-fatal heart attacks, and strokes. Compared to women on the placebo, subjects who took medication had 43 percent fewer deaths, 59 percent fewer non-fatal heart attacks, a 39 percent decrease in the need for bypass surgery, and a 59 percent drop in the risk of stroke.

Although much research needs to be done, certain gender differences have emerged with respect to heart disease. Women generally develop cardiovascular disease later in life than men and are at greater risk of fatality once it has developed. For reasons that are not

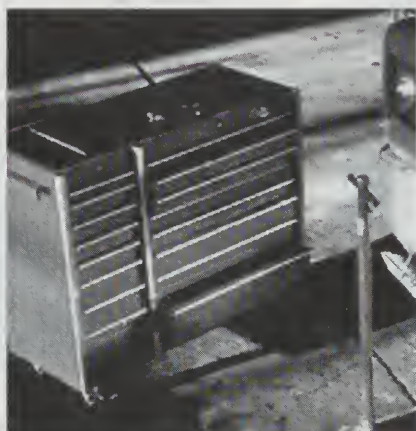


clear, stress tests are less predictive of CHD in women than in men. Moreover, women seem to suffer more complications after such cardiovascular procedures as angioplasty, bypass surgery, and coronary atherectomy.

Women also may be less sensitive than men to certain cardiac warning signs, such as chest pain or shortness of breath. Trained to be caretakers, and sometimes unaware of the risks of cardiovascular disease, many women may present symptoms in ways that are not always obvious. "I always have my antennae up," notes cardiologist Jacqueline Schwanwede, MD. "Some women tend to minimize discomfort, put their own complaints in the background, and talk about their families instead."

As awareness of heart disease continues to grow, more women will be talking about their cholesterol. **NJM**

Only MIIX offers



the Toolkit that fits in your briefcase.

Provided by MIIX Financial Services

The MIIX Toolkit, designed specifically for physicians, explains how you can access:

- **MIIX Buying Service** — offering discounts up to 70% on quality medical and office supplies and equipment.
- **Equipment Leasing** — equipment lease financing and lines of credit at competitive rates.
- **Receivables Management** — providing collection of medical accounts receivable.
- **MIIX Capital Management** — investment consulting services for physicians and other high net worth individuals.

To find out more about this powerful resource,
call MIIX Financial Services at

1-800-227-MIIX.

Endorsed by the

Medical Society of New Jersey

MSNJ

MEDICAL INTER-INSURANCE EXCHANGE
POWERFUL PARTNERSHIPS



PUBLIC HEALTH AND MEDICINE: WORKING TOGETHER

Marilyn A. Gorney, DO
Sindy M. Paul, MD, MPH
Martin T. Zanna, MD, MPH
Leah Z. Ziskin, MD, MPH

The authors are affiliated with the New Jersey Department of Health and Senior Services, Preventive Medicine, Public Health Residency Program.

Historically, the relationship between public health and medicine has not always been a collaborative one, despite its early complementary origins. In the time of Hippocrates, "understanding the physical and social dimensions of community life was essential to treating the problems of individual life."¹ Over time and through many scientific advances, particularly those of the 20th century, the disciplines of public health and medicine grew separately. Each acquired its own analytical tools and understanding of health and illness. Medicine focused on the individual and public health focused on populations.

Today, both public health and medicine face great challenges in a changing health

care environment where threats to the health of individuals as well as to entire populations continue. In working together, as originally intended, however, mutual goals may be achieved, giving benefits to all. Indeed, both disciplines share many similarities; both rely heavily on scientific methodology, epidemiology, and biostatistics.

Just as physicians in clinical practice receive residency training in a clinical specialty, public health physicians receive residency training in preventive medicine. There are over 80 accredited preventive medicine residency training programs in the United States, located in medical schools, schools of public health, health departments, and federal and military facilities. Residents training in preventive medicine may choose to concentrate in one or more areas of general preventive medicine: public health, occupational medicine, aerospace medicine, and undersea medicine.

Preventive medicine is one of the 25 medical specialties recognized by the American Board of Medical Specialties. Established in 1947, the American Board of Preventive Medicine is one of the older boards. Preventive medicine/public health has been a recognized specialty in the United States for 50 years.

Public health is the application of preventive medicine techniques to a population. Just as clinicians have been facing a rapidly changing health care system, public health physicians have been facing similar challenges. As emphasized in *The Future of Public Health*, public health activities in the United States have fallen into disarray.² Public health has been unable to accomplish its mission to fulfill "society's interest in assuring conditions in which people can be healthy."² Indeed, critics of public health have claimed that many public health issues such as substance abuse, teenage pregnancy, and AIDS have not been ade-

quately addressed. In actuality, public health problems have greatly increased in complexity and diversity, requiring more support, leadership, and awareness than ever before. "The wonder is not that American public health has problems, but that so much has been done so well, and with so little."² Additionally, the disparity in public health has not been adequately addressed due to a shortage of public health physicians. According to the American College of Preventive Medicine, there is a long-term, continuing national shortage of physicians in preventive medicine. In 1991, there was a total of 3,678 board certified preventive medicine physicians; this was 50 percent less than needed according to projections based on national workforce studies.³

The practice of public health often is taken for granted. In fact, public health measures actively and continually protect us and our patients in daily life. Public health activities allow us to detect, investigate, and control foodborne disease outbreaks. Tracking infectious diseases, surveillance for emerging pathogens and antibiotic

resistant bacteria, providing guidelines for prevention, and postexposure management are critical public health functions. Public health also is concerned with preventing injury and accidents through the development and promotion of car safety features, bike helmets, and job/worker safety, including occupational exposure management. Promoting health through education on issues such as tobacco, substance abuse, and AIDS also is a prominent public health activity. Prevention activities extend to pediatric and adult vaccinations, prenatal care, and lifestyle modification recommendations. Through all these activities, public health physicians work to achieve positive health policy changes and implementation.

We have grown accustomed to a certain sense of security that all of these functions are carried out and that we are protected. In fact, many threats to public health have emerged during the 1990s. Pathogens such as tuberculosis have re-emerged as drug resistant; common bacteria now are resistant to antibiotics; variant strains of HIV make it more dif-

ficult to diagnose patients and protect the blood supply; and outbreaks of waterborne diseases such as *Cryptosporidium* have affected entire cities in spite of filtration and chlorination. There have been historical predictions that infectious diseases would wane, but infectious disease mortality has been increasing in the United States.⁴ Diseases once thought to be eradicated in developed nations have resurfaced. After a recent outbreak of dengue fever in the Mexican state of Tamaulipas, ten miles south of the Texas border city of McAllen, seven cases of dengue fever were diagnosed in Texas.⁵ Recent outbreaks of Ebola hemorrhagic fever in Zaire and plague in India have heightened concern about the potential for importation of these diseases into the United States.⁴

Smoking and tobacco use, accidents, violence, and substance abuse also contribute to morbidity and mortality in the United States. The public currently is advocating for more preventive approaches to disease, crime, and social problems. At the same time, medicine is increasingly seeking

ways to promote health and prevent disease. Some of these approaches are empirically based, as science has developed evidence for the effectiveness of preventive interventions.⁶ Education, awareness, and well-designed prevention strategies can yield improved outcomes and decrease morbidity and mortality. Modification of lifestyle habits such as the use of tobacco, alcohol, and drugs; infrequent exercise; inadequate diet; unprotected sexual activity; lack of prenatal care; and not using seatbelts can have a major impact on the nation's health. These lifestyle modifications could reduce all cases of acute disability by one-third, decrease cases of chronic disability by two-thirds, and prevent 40 to 70 percent of premature deaths.^{7,8}

Public health physicians play a unique role in medicine. They are in a position to work with government officials to establish and implement sound health care policy and to influence legislation, in contrast to other clinical specialties. The

need for and importance of physicians in public health and government have been thought by some to have never been greater than in today's health care climate. Public health physicians need skills in developing and evaluating outcomes measures and medical guide-



© Williams & Philips

lines. Public health physicians are needed to combine medical training with specialty knowledge of population-based medicine and legislative issues. Public health physicians engage in consensus building among health care providers, administrators, and government officials.

It is extremely important to maintain public health graduate medical education in public

health departments after training in a clinical setting for those physicians who choose to specialize in keeping people healthy through population-based medicine. As with other medical specialties, an appropriate training site where the specialty is practiced is needed; training in public health can appropriately be achieved through a public health department-based program. New Jersey's Public Health Residency Program at the New Jersey Department of Health and Senior Services (DHSS) is in its 30th year of training residents choosing to specialize in public health.

DHSS recognizes the need for collaborative efforts between medicine and public health in New Jersey. DHSS has consistently reached out to the medical community to collaborate on public health initiatives and policies.

A few recent examples of such collaborative efforts include combining clinical experience and expertise in treating HIV/AIDS patients

where practicing physicians worked with DHSS to modify current public health policies regarding the availability of medications on the AIDS Drug Distribution Program formulary; DHSS has worked with other practicing physicians and health professionals to develop surveillance systems and approaches to emerging and resistant pathogen threats such as HIV variants, resistant strains of HIV, and antibiotic resistant bacteria; physicians within and outside DHSS have been actively involved in developing outcomes measures.^{9,10}

On a national level, leaders in medicine, public health, and government have begun to organize. This initiative, hailed by Donna Shalala, secretary of the Department of Health and Human Services as a "golden opportunity to form a 'more perfect union' of medicine and public health," is a cooperative and collaborative effort to improve health and health care. As former Surgeon General C. Everett Koop stated in his address to participants of this initiative, "There's more at

stake than income and turf; the health of the nation is at stake."¹ Both private practice and public health physicians have been markedly impacted by health care reform and practice changes within their specialty. It will take the cooperative effort of physicians in private practice together with physicians with public health training and experience to help maintain a health care system whose primary goal is to improve the health of individuals and populations.

References

1. Reiser SJ: Medicine and public health. Pursuing a common destiny. *JAMA* 276:1429-1430, 1996.
2. Institute of Medicine, Committee for the Study of the Future of Public Health: The future of public health. Washington, DC, National Academy Press, 1988.
3. American College of Preventive Medicine: Careers in preventive medicine. 1993.
4. Pinner RW, Teutsch SM, Simonsen L, et al.: Trends in infectious diseases mortality in the United States. *JAMA* 275: 189-193, 1996.
5. Dengue fever at the U.S.-Mexico border, 1995-1996. *MMWR* 45:841-844, 1996.
6. American College of Preventive Medicine: The specialty of preventive medicine. Leadership in medicine for the 21st century. A report of the forum for leadership in the specialty of preventive medicine. September 1996.
7. Sullivan LW: Healthy People 2000. *N Engl J Med* 3323:1065-1067, 1990.
8. McGinnis JM, Foege WH: Actual causes of death in the United States. *JAMA* 270:2207-2212, 1993.
9. Statewide surveillance for antibiotic resistant bacteria—New Jersey, 1992-1994. *MMWR* 44:504-506, 1995.
10. Paul SM, Finelli L, Crane GL, Spitalny KC: A statewide surveillance system for antimicrobial resistant bacteria: New Jersey. *Infection Control Hosp Epidemiol* 16:385-390, 1995.

PRESCRIPTION FOR EFFECTIVE COMMUNICATIONS WITH OLDER PATIENTS

Phil Bruschi

"I get so nervous at the thought of asking the doctor questions. I'm afraid I won't understand the answers." "I wish my doctor would talk a little slower. I get confused." "Did the doctor say to take two pills once a day or one pill twice a day?" Such statements and questions are typical of all patients to some degree, but they are more prevalent among older patients.

Effective communication in health care is no less a challenge than in any other service-oriented business or profession and, in fact, may be more of a challenge with the multitude of changes in health care.

One major change is the aging of the population. People are living longer than ever, and they want to know more about healthy aging. The request for more information and education brings another challenge to physicians—communicating with patients.

Scientific research has identified some changes associated

with normal aging that affect the communication process, including greater difficulty paying attention causing short- and long-term memory problems; slower thinking so overall thinking and memory systems become somewhat less efficient as people age; slower recall, which is the ability to retrieve information from long-term memory and bring it into short-term memory; less frequent use of memory strategies such as visualization and association to enhance memory; depression, which can affect attention, concentration, and recall; sensory impairment that impedes the ability to receive information; and loss of confidence for daily activities that once were routine.

But the question is, "What constitutes effective communication?" Physicians having good communication skills are viewed by their patients as providing them with high-quality medical care. Thomas S. Inu, chair of Harvard Medical School's Department of Ambulatory Care and Prevention and Director of Primary Care states, "The patient tends to judge clin-

ical knowledge and technical skills through the lens of the individual's interpersonal qualities." Many physicians value technical expertise/clinical skills more highly than good communication, while patients ranked both technical skills and communication skills high.

A survey by the American College of Physicians revealed that while patients ranked communication number two, doctors ranked it sixth of the key elements for quality outpatient care. A study by the Bayer Institute for Health Care Communication found 83 percent of physicians recognize the importance of good communications; however, physicians and patients differ on their definitions of communications. For example, 72 percent of patients believed that having physicians listen to their health concerns was extremely important, while only 52 percent of the physicians surveyed agreed. And 66 percent of the patients surveyed felt physicians should ask about patients' general health; 29 percent of the physicians surveyed agreed.

Christine Laine, MD, assistant professor of medicine at Jefferson Medical Center in Philadelphia, says that medical training stresses getting information from patients, but little on imparting information and explaining information. Laine adds that the typical ten-minute office visit does not promote effective communication. She believes patients should "become a bit more bold, a bit more aggressive in asking for information."

Yet, it is difficult for most patients to ask questions, and more difficult for older patients, who may lack self-confidence, have a vision or hearing impairment, or find it increasingly difficult to concentrate with distractions. Physicians need to take more time to explain fully to all patients or to ensure that patients understand what was said; this effort will go a long way in building a better physician/patient relationship as well as increasing the likelihood that the treatment plan prescribed will be implemented by the patient.

Mark Parker, MD, an emergency medicine physician, says physicians should provide patient education pamphlets; he feels having written handouts and other health-related information available to patients will improve patient retention. "This reinforces your

message," according to Parker who feels the extra time and minimal extra cost makes information more user-friendly and can be of great value to the patient and any family caregivers once the patient leaves the hospital or office.

This lack of retention may be exacerbated for older adults who already may lack confidence in taking in new information and who are feeling more stressed than are younger patients. In a study reported in *Educational Gerontology*, the best way to improve the likelihood of patients following medication instructions and to enhance physician/patient communication is to give older patients written lists to follow for treatment or information. Rost and Roter found that of 83 elderly clinic patients in a post-visit study, 46 percent could not recall their medications. Fifty-two percent could not recall lifestyle recommendations that had been given to them. The way in which this information was communicated during visits was found to be related to patients ability or inability to recall this information.

How can physicians and patients contribute to a more effective communication partnership?

Physicians can present information to older pa-

tients to enhance patient understanding and retention by following the tips.

- Select your words carefully:

1. Stay away from technical medical jargon; instead use lay terms.

2. Use clear words that will communicate your intended meaning.

3. Be concise and cut out unnecessary words.

4. Use straightforward but tactful language.

5. Consider the words you select so as not to trigger negative emotions or defensiveness.

6. Do not to speak in a patronizing manner.

- Select a rate of speaking that is appropriate for the complexity of the situation and the patient's understanding.

- Move to a quiet place away from external distractions, when necessary.

- Be as organized as possible in presenting your message.

- Use analogies, examples, or illustrations to make complex information more understandable.

- Observe patient's non-verbal behavior for clues to determine what is understood.

Physicians should encourage older patients to

partner in the communication process by encouraging patients to use these techniques.

- Share the responsibility for effective communication.
- Think through what you want to say ahead of time (questions, occurrences of problems, and symptoms) or bring written questions.
- Ask for clarification and information to aid in understanding and remembering. By using exploratory (who, what, where, when, and why) questions, all sides of a medical problem can be examined by gathering pertinent facts and evaluating the evidence to make sound decisions.
- Bring someone with you who can help take in and remember important information.

• Take notes or bring a small tape recorder to record instructions for care or next steps.

• Educate yourself about your health. Know your medical history.

• Actively listen and concentrate on what is being said. Give your full attention at all times. This will take hard work especially when you are not feeling your best or are in pain.

• Express how you are feeling. This means with anything

that is bothering you from pain and confusion to misunderstanding.

- Summarize your understanding of what your physician has discussed.

Physicians can improve their understanding and retention of patient information by keeping in mind the following suggestions.



• Practice listening techniques, such as paraphrasing, summarizing, restating, and observing non-verbal clues.

• Realize that you can recall patient information easier when you have a full understanding of the patients' needs.

• Listen between the lines by focusing your attention on the patient's cues—voice and non-verbal expressions.

• Give special attention to information that the patient repeats.

• Reflect on your own attitudes and behaviors regarding listening, customer service, and time management as they relate to the communication process.

• Put the patient's needs to speak and be understood before your own needs.

• Observe and take in as many details as possible when interviewing and examining.

• Ask questions that give you specific information.

• Provide immediate feedback that reflects your level of clarity and understanding of patients' needs and concerns.

• Use verbal elaboration. When you learn something new, talk about it and teach others.

Conclusion. The significance of partnering between older patients and physicians for effective communication cannot be overstated. When working together and sharing the responsibility for better communication, the benefits include building trust; lessening mistakes; providing more and accurate information; promoting better understanding of patient and physician needs; and promoting mutual respect and learning.

NJM

In the face of change, many look to the strength and guidance of Summit Bank's Commercial Banking services. Our top management has worked alongside community business leaders for decades. We're also proud of our long history of developing innovative business solutions. Our wealth of products and services include Commercial Lines of Credit, Cash Management, Equipment Leasing and much more. With Summit, there's no need to wonder if your commercial banking solution will work. We will customize our products, any which way, until they do work. Looking for consistency, stability and service? Your search is over.

Call us. 1-800-852-1512.

COMMERCIAL BANKING

*Commercial Loans
Commercial Lines of Credit
Asset Based Financing
Commercial Real Estate
Cash Management
Foreign Exchange
International Trade Finance
Equipment Leasing
Equipment Financing
Structured Finance
Private Placements
Mezzanine Financing
Aircraft Financing*

Reach Higher

**SUMMIT
BANK**



THE WINDS OF CHANGE
ARE BLOWING.

DO YOU DARE TO WAIT
FOR THE STORM?

Summit, Summit Bancorp and Reach Higher are registered service marks of Summit Bancorp • Summit Bank is a service mark of Summit Bancorp.

Breaching physician-patient confidentiality to protect public welfare

Russell L. McIntyre, ThD

Dr. McIntyre is professor of medical ethics and health law, Department of Environmental and Community Medicine, UMDNJ-Robert Wood Johnson Medical School, in Piscataway.

John DeCurtis was a New Jersey Transit train engineer who suffered from diabetes, was insulin-dependent, had diabetic retinopathy—a progressive condition—and was color blind. On February 9, 1996, he ignored a red “stop” signal in Secaucus and caused a train crash that killed him and two other people. DeCurtis had concealed from his employer the fact that he had diabetes by not acknowledging his disease on his annual physical examination forms. He also concealed relevant information about taking medications and being under a doctor’s care. His regular private physician, however, knew of his complete medical condition and was aware that he was employed as a train engineer but took no action to notify DeCurtis’s employer of

this physical impairment or of the fact that as long as DeCurtis continued in his present job assignment, the public was in danger.

DeCurtis, in fact, had eye surgery twice to slow the progression of the disease but paid for it out of his own pocket rather than file insurance claims with New Jersey Transit.

A year after the accident, the *Associated Press* ran a wire story about this incident that asked the question as to whether DeCurtis’s personal physician had any ethical or legal obligation to breach doctor-patient confidentiality and report DeCurtis’s dangerous condition to his employer.

Although maintaining doctor-patient confidentiality is one of the oldest obligations of the physician, dating back to Hippocratic times and enshrined in the Hippocratic oath, it has been one of the most difficult concepts to apply to medical practice. It is difficult because the confidential information of which the doctor is privileged has implications for other indi-

viduals and, even, for society. This article explores the physician’s difficult position as he/she tries to balance professional responsibility to the patient with social accountability to public welfare.

There are several difficulties given the present case. First, if we assert that there is an ethical responsibility to report the engineer, that ethical “duty” may be different than a legal “duty.” For example, the legal concept of “duty” is a concept established by law, i.e. either by a legislature through the enactment of a statute or by a court (judge) in the “holding” of a case (case law). It is only the existence of a legal duty that requires someone to act accordingly, i.e. an affirmative duty to disclose or report. To assert an ethical duty that is not also a legal duty would not have the same implication. Second, the train engineer’s personal physician in this case practiced medicine in New York and it is not clear that a legal duty imposed by one state would require someone living and practicing in another state to honor that requirement. (If there is a

statutory requirement to break confidentiality and make a report, the statute always grants immunity from civil or criminal prosecution to the one who is required to break confidentiality as long as the report is made in good faith. It is not at all clear that this immunity provision would be recognized or valid in another jurisdiction.)

Despite the problems noted, this article delineates both an ethical and legal duty that would require the physician to break doctor-patient confidentiality and report the dangerous condition to the patient's employer.

Statutory requirements to break physician-patient confidentiality. In New Jersey, a physician is required to break doctor-patient confidentiality and make appropriate reports to various agencies under the following circumstances:

1. Suspected child abuse or neglect [N.J.S.A. 9:6-8, 10; 9:6-8, 14].
2. Knife and gunshot wounds, including self-inflicted and accidental [N.J.S.A. 2C:58:8].
3. Communicable diseases [N.J.S.A. 26:4-15].
4. Any epileptiform seizure [N.J.S.A. 39:3-10.4].
5. Certain medical conditions that might lead to blindness [N.J.S.A. 30:6-1.2 (Revised, 1986)].

6. Animal bites of persons [N.J.S.A. 26:4-79].

7. A threat of harm to a known third party [*McIntosh v. Milano*, 168 NJ Super 466].

In addition, following the attempted assassination of President Ronald Reagan, Congress passed a federal law making it a crime for anyone to make a threat of harm against the president, vice-president, members of Congress, or members of the federal judiciary. A report must be made immediately to the local office of the Federal Bureau of Investigation.

Advice of the American Medical Association (AMA). Professional societies frequently have commented on the importance of maintaining physician-patient confidentiality. In 1957, the older version of the *Code of Ethics* of the AMA included the following language under Section 9: "A physician may not reveal the confidences entrusted to him in the course of medical attendance or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community."

A more recent formulation of that advice appears in a policy statement of the AMA's Judicial

Council: "The obligation to safeguard the patient's confidences is subject to certain exceptions which are ethically and legally justified because of over-riding social considerations. Where a patient threatens to employ serious bodily harm to another person, and there is a reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim, including notification of law enforcement authorities. Also, communicable diseases and gunshot and knife wounds should be reported as required by applicable statutes or ordinances."¹

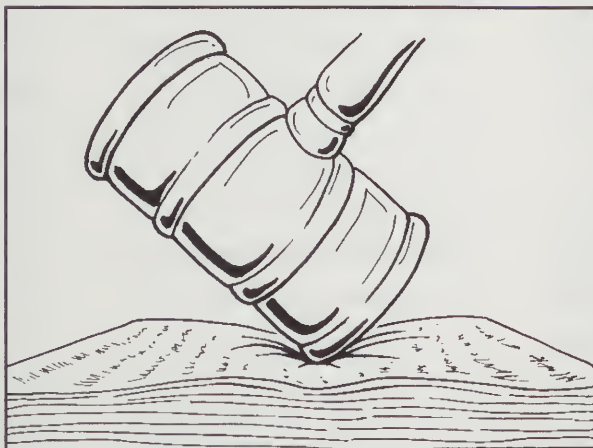
The state Board of Medical Examiners' (BME) regulation on medical records, *N.J.A.C. 13:35-6 (d)*, states: "Licensees shall maintain the confidentiality of professional treatment records, except that: . . . (4) The licensee, in the exercise of professional judgment, who has a good faith belief that the patient because of a mental or physical condition may pose an imminent danger to himself or herself or to others, may release pertinent information to a law enforcement agency or other health care professional in order to minimize the threat of danger."

It is interesting to note that the New Jersey Board of

Psychological Examiners has taken a more active role in defining a licensee's responsibility. Under *N.J.A.C. 13:42-8*, Client Records: Confidentiality, the Board states: "A licensee shall preserve the confidentiality of information obtained from a client in the course of the licensee's teaching, practice, or investigation. However, the licensee shall reveal the information . . . if in the licensee's judgment, exercised in accordance with the standards of the profession . . . (1) There is a clear and imminent danger to the individual or the public. . . ."

The physician as advocate for public health and welfare. Almost as old as reference to physician-patient confidentiality is the acceptance of the belief that the physician is an advocate for—and protector of—the public's health and welfare. In American case law this has been especially true when communicable diseases have been at issue. For example, in a case in Nebraska in 1920 a physician diagnosed syphilis and advised the patient to leave town to prevent the spread of the disease and not to return to the rooming house where he had been living. The man, apparently, said he would follow the

physician's advice but the next day changed his mind. The physician, believing that the health of the other residents of the rooming house was in danger, informed the manager of the hotel that the patient had a "contagious disease" and advised her "to disinfect his bed clothing and wash her hands in alcohol afterwards."² The manager moved the



man's belongings into the hallway and forced him to vacate the roominghouse. The patient, outraged by the doctor's action, sued the physician for "breach of confidence." In this case, the court stated that "the physician could successfully defend such an action if the physician reasonably believed the patient had a dangerous and 'highly contagious' disease that likely would be spread to others, and the physician made only such disclosure as was necessary to prevent the spread of the disease. In such a case the court found that the physician might actually

have a 'duty to the public' to warn others and, accordingly, affirmed a judgment in favor of the physician. This case has long stood as the leading case on doctor-patient confidentiality."³

The most significant national case involving a breach of the confidential relationship between therapist and patient is the *Tarasoff* decision from the California Supreme Court.⁴ In 1969, two foreign students—both from Brazil—dated. On one of the evenings they kissed goodnight. The male student, apparently, interpreted the kiss in terms of the cultural perspectives that he thought they both shared. To him, the kiss meant that she was ready to commit herself to him for life. When he proposed marriage, she rejected his offer and ridiculed his interpretation of her gesture.

The incident occurred just before the summer break when she was to return to Brazil. The male student, who was in therapy with a psychotherapist, was so angry and humiliated that he told his therapist that when Tarasoff returned in the fall, he was going "to kill her." The therapist believed that the student was serious and that he had the means at his disposal to carry

out the intended threat. After consulting two of his professional colleagues at the Counseling Center of the University of California, the therapist wrote a letter detailing all of the pertinent information and sent it to the campus police. The campus police investigated but, believing that the student was not dangerous, released him and did nothing further. Soon after Tarasoff returned from Brazil, the male student went to her apartment and stabbed her to death with a kitchen knife.

The parents of Tarasoff sued both the university and the psychotherapist for failing to notify the intended victim of the threat against her life. The California Supreme Court held that "a psychotherapist with knowledge of an intended crime has an obligation to make a judgment as to the possibility of that crime and specifically to inform the intended victim."⁵

New Jersey case law. New Jersey has had several cases that bear on the question at hand: Did the physician have an overriding social responsibility to break confidentiality and make a report to protect an individual or the public from harm? We examine two relevant cases from New Jersey.

McIntosh v. Milano [168 N.J. Super. 466]. On July 8, 1975, Lee

Morgenstein, age 15, shot and killed Kimberly McIntosh, age 21. Morgenstein had been a patient of board-certified psychiatrist, Michael Milano, MD. Despite their differences in age, the two, according to court records, had been involved in a sexual relationship which "overwhelmed" the younger Morgenstein. He, in fact, developed "possessive feelings" toward her and was alarmed that she dated other people. He expressed feelings of jealousy and hatred toward her other boyfriends. He was angry when she moved because he was not able to get her address or telephone number. When he finally found her, he got her to go with him "to a local park area where he fatally shot her in the back." The mother of the victim then sued Dr. Milano—using *Tarasoff* principles—for failing to take appropriate steps to warn McIntosh that her life was in danger.

In this case, the court held that "the concept of legal duties for the medical profession is not new. A doctor-patient relationship in some circumstances admittedly places a duty to warn others of contagious diseases. New Jersey recognizes the general rule that a person who negligently exposes another to a contagious disease, which the other contracts, is liable in dam-

ages....Specifically, a physician has the duty to warn third persons against possible exposure to contagious or infectious diseases, e.g. tuberculosis, venereal diseases, and so forth."

The court held that "the relationship giving rise to that duty may be found either in that existing between the therapist and the patient, as was alluded to in *Tarasoff II*, or in the more broadly based obligation of a practitioner to protect the welfare of the community, which is analogous to the obligation a physician has to warn third persons of infections or contagious disease. That analogy also may be applied in a somewhat different fashion. To an admittedly uncertain but nevertheless sufficient extent, 'dangerousness' must be considered identifiable...and although not a 'disease' as that term is commonly used, may affect third persons in much the same sense as a disease may be communicable. The obligation imposed by this court, therefore, is similar to that already borne by the medical profession in another context." "Although New Jersey has recognized the physician-patient privilege (*N.J.S.A. 2A:84A-22.1 et seq.*)...the need for confidentiality cannot be considered either absolute or decisive in this setting. A patient is entitled to

freely disclose his symptoms and condition to his physician in confidence 'except where the public interest or the private interest of the patient so demands.' A patient, therefore, possesses a 'limited right' to confidentiality in extra-judicial disclosures, 'subject to exceptions prompted by the supervening interests of society (*Hague v. Williams*, 37 N.J. 328, 336 (1962), just as a lawyer has no privilege in the lawyer-client relationship to protect or conceal intent to commit a crime." The court comments: "Other medical writers have acknowledged a duty to disclose when compelled by law or if an imminent danger to the patient or to society exists," and concludes, "(t)hus, considerations of confidentiality have no over-riding influence here." ⁶

State v. Schreiber [91 N.J. 575, 585 A.2d 945 (N.J. 1991)]. Linda Schreiber, driving alone, was involved in a single-car accident on November 17, 1986. Her car skidded off the roadway and flipped over. She was thrown from the vehicle and found unconscious and seriously injured by Hopewell Township police. She was transported by rescue squad to The Medical Center at Princeton, where she remained for almost a month. At the hospital, medical personnel

conducted several tests, including a blood test, for diagnostic purposes. The police were not present at the hospital and made no request for specific tests.

Schreiber was discharged 28 days later. The day following her discharge, which was one day before the statute of limitations was to expire for filing "Driving While Intoxicated" (DWI) charges against her, a physician from the emergency room at The Medical Center at Princeton, telephoned Hopewell Township Police and informed them that Schreiber was legally drunk when admitted to the hospital. The police, having had no suspicion that she was DWI at the time of the accident, charged her immediately with DWI and careless driving. Schreiber was fined, convicted of DWI, had her license suspended for six months, and was sentenced to 12 to 48 hours detention at an Intoxication Drivers Resource Center. Schreiber moved to have the medical evidence suppressed on the basis that the police obtained it in violation of the confidentiality of the doctor-patient relationship. The court denied her motion and she appealed her conviction to the Appellate Division.

The Appellate Division, however, accepted the argument that "the record of the blood test

must be suppressed . . . because there was a violation of the statutory patient-physician relationship by the physician . . . (and) the statute [N.J.S.A. 2A:84A-22.2] barred the police . . . from disclosing . . . the information that the physician had improperly disclosed. . . ." ⁷ The Appellate Court reversed the lower court's conviction and remanded the case back for a re-hearing based upon the rejection of the medical evidence upon which the conviction was based.

The Supreme Court of New Jersey, however, granted certification to review the Appellate Court's decision to disallow the medical evidence based upon the court's interpretation of the doctor-patient confidentiality privilege. Justice Garibaldi, writing for a unanimous Supreme Court, held that the Court's "rules of evidence" statute did not apply in this specific instance in defining limitations of the confidentiality privilege between doctor and patient. The Supreme Court, acknowledging its own language in *Hague v. Williams*, 37 N.J. 328, 336 (1962), repeated that "the right of confidentiality is limited by 'the supervening interests of society.'"

The Court declared that it is "not called upon to decide whether the emergency room physician in this case violated

any ethical duty imposed on him by his profession . . . [but confirmed that since] (t)he primary [legislative] purpose behind New Jersey's drunk driving statutes is to curb the senseless havoc and destruction caused by intoxicated drivers [*State v. Tischio*, 107 N.J. 504, 512, 514 (1987)] . . . it cannot tolerate the suppression of evidence blamelessly received by the police from an unquestionably voluntary source."⁸ The conclusion of the case recognized that the emergency room physician did not violate the legal duties imposed on the confidentiality requirements of the doctor-patient privilege in his effort to protect public welfare.

Conclusion. I have argued that there are significant case law precedents for breaching confidentiality when a doctor has reason to believe that another person—or the public—is in imminent danger, because of the patient's mental or physical condition and disclosure is necessary to protect an identified individual or the public from harm.

I also have acknowledged, however, that there is no specific statute, policy, or regulation that requires a physician in New Jersey to do this. BME might want to consider adopting such a

regulation for physicians practicing in this state. Physicians might respond by stating that the risk of being sued is too great to warrant such a broad rule. But, *Tarasoff* might be instructive here. Recall that the treating psychologist actually consulted with two professional colleagues before making the report to campus police. Perhaps BME would find it advisable to establish an ethics committee within BME that could be available to physicians who have reason to believe that a patient is dangerous and might harm another person or the public but who want a "second opinion"—on an emergent basis—before making a report to a threatened individual or to the police. This ethics committee would function much in the same way as an ethics committee functions for New Jersey hospitals when difficult ethical or legal issues are involved in patient care decisions.

One final piece of information supporting my claim that there are supervening social obligations that a doctor has to break confidentiality and report dangerous medical conditions is that there has never been a successful suit against a physician—anywhere in the United States—when confidentiality has been breached in good faith to protect

an individual or the public from harm. It is exceedingly clear that the courts want physicians to make professional judgments and to take appropriate action to protect the public from harm; it also is clear from this lack of successful suits against physicians that the courts want to protect physicians when they act in good faith and take this kind of personal and professional risk.

References

1. Current Opinion 5.05, Judicial Council, American Medical Association.
2. *Simonsen v. Swenson*, 177 N.W. 831 (Neb., 1920).
3. Annas, GJ: Confidentiality: What should the doctor tell the inquiring employer? *Orthopaedic Review* 3:10, 1974.
4. *Tarasoff v. Regents of the University of California*, 551 P.2d 334 (Calif. Sup. Ct. 1976).
5. Hankoff LD, Nattland C: Clinical confidentiality: Dilemmas and guidelines. *NJ MED* 83:10, 1986.
6. *McIntosh v. Milano*, 168 N.J. Super. 466, 474, 483-84, 489-90, 490, 493.
7. *State v. Schreiber*, 240 N.J. Super. 507, 510.
8. *State v. Schreiber*, 91 N.J. 579, 585 A.2d 945, 949.

NEW OPPORTUNITIES UNDER THE 1997 TAX LAW

Frank Castellon

Mr. Castellon is director of Investment Services at MIIX Capital Management.

The Tax Relief Act (TRA) of 1997 provides for \$152 billion in tax cuts between now and the year 2002. TRA also provides for tax increases of about \$56 billion, thus yielding a net tax cut of \$96 billion. Since the government is scheduled to collect over \$9 trillion in taxes over this same time frame, the tax cut represents an almost insignificant decrease in collections of 0.6 percent.

Most of the tax benefits accrue to taxpayers whose adjusted gross income is less than \$40,000 and have children. Nevertheless, TRA does present opportunities for those with higher incomes to decrease their taxes. This article explores the significant provisions showing how to maximize the effect of TRA on financial and investment planning, concentrating on capital gains taxes, estate and gift taxes, the sale of personal residences, retirement planning, and children's education.

Capital gains taxes.

Previously, the taxes on net capital gains were capped at 28 percent. Under TRA, effective

for tax years ending after May 6, 1997, taxpayers in all tax brackets realize an advantage. The maximum tax rate generally is lowered to 20 percent for investors in all but the 15 percent tax bracket. For investors in the 15 percent bracket, the capital tax rate is essentially 10 percent. There are certain rules about how long the assets must be held to receive maximum benefits.

Many investors have sizeable assets in mutual funds. According to published data, American investors paid over \$19 billion in taxes in 1995 on mutual fund assets. Now that the tax law has a significant differential on the tax rates paid on current income (dividends and interest for mutual funds) and capital gains, the evaluation process for appropriate mutual funds must include an assessment of the fund's portfolio turnover. For example, investors holding assets in mutual funds that do a lot of active trading in taxable accounts, should consider switching to tax sensitive mutual fund portfolios to decrease the tax bite at year end. Remember that mutual funds, by law, must pass on 95 percent of all earnings and capital gains each year.

Investors holding low cost basis stocks should consider selling some of the stock over a period of time to diversify their investments. This is particularly true if stock options or sizeable stock holdings in a single company have been received.

Lower capital gains rates also may make real estate investment trusts (REITs) look more attractive. A portion of REIT dividends generally is classified as the nontaxable return of capital. This treatment lowers the tax basis and converts current income to capital gains when the REIT shares are sold.

As in the past, all earnings and appreciation in variable annuities are taxed as ordinary income when received. Other investment securities enjoy a split between treating dividends and interest as ordinary income and treating appreciation as capital gains. Now that capital gains rates are lower, the disparity could make a variable annuity less valuable in one's portfolio. This is particularly true considering the expenses associated with annuities.

Collectibles such as stamps, coins, and artwork are excluded from the new law, so that

capital gains on these assets will continue to pay 28 percent. The capital markets may react to this exemption by not valuing collectibles in the long run as highly as in the past.

Estate and gift taxes. In the area of estate and gift planning, the most publicized change is the increase in the unified credit to \$1 million beginning in 2006 and thereafter. The unified credit is the amount of assets in an estate that can be transferred tax free if certain legal steps are taken. Since a married couple can each take the unified credit, it is possible after the year 2006 to transfer up to \$2 million in assets to beneficiaries on an estate tax-free basis. The present credit is \$600,000; therefore, the increase to \$1 million represents an increase in assets of less than 6 percent per annum over the next nine years. Historically, the equity markets have yielded better annual returns than 6 percent, so even with the increased credit, one can expect that potential estate taxes will be higher in 2006 than they are today if a person is to take advantage of the capital markets to increase the value of assets.

There is, however, a new estate tax exclusion feature that applies to owners of closely held family businesses. This exclusion, when combined with the unified credit, offers the opportunity to transfer to bene-

ficiaries up to \$1.3 million in value. This new exclusion is available only for qualifying businesses that are comprised of a substantial portion of the taxpayer's estate and meet stringent participation and ownership requirements. The amount of the exclusion varies proportionately to the increase of the unified credit, so that the taxpayer always has a total of \$1.3 million in deductions available in every year between now and 2006 or thereafter.

In addition, there are other less publicized changes. For example, the \$10,000 per year gift tax exclusion will be adjusted for inflation beginning in 1999 and thereafter. Other transfer taxes also will be indexed with inflation.

The rules for charitable remainder trusts and certain revocable trusts also are changed. For example, charitable remainder trusts may not be as attractive as they once were because the rule changes limit their applicability to younger philanthropists. In contrast, taxpayers again can deduct the full market value of gifts made to private family foundations rather than their cost basis, which is a lower number.

Sale of personal residences. Under the new rules, up to \$500,000 of capital gains on the sale of a personal residence may be excluded from capital gains taxation

(\$250,000 for a single taxpayer). Even if the gains on the sale of a personal residence exceed the exclusion amounts, the new and lower capital gains rates will apply to the excess. The new rule can be applied once every two years whereas the old rule could be used only once. If the taxpayer is transferred or has to sell a new home for health or other unforeseen circumstances in less than two years, the exclusion still will be available for a pro rata share of the capital gains.

The effect of this change is to simplify the records kept with respect to home improvements and prior sales of personal residences.

Retirement planning. The changes in the relative taxation of capital gains versus dividend and interest income may affect the recommendations concerning the types of securities to be held in qualified retirement plans versus other personal retirement accounts. For example, it may be possible to place equity securities in taxable accounts and fixed income instruments in qualified retirement plans in such a manner that total taxes on retirement assets are minimized and the growth of capital available for retirement maximized. This possibility is increased now that TRA also has repealed the excess distribution and accumulation taxes on qualified retirement plans, tax-sheltered annuities, and IRAs for distribu-

tions received after December 31, 1996, and for estates of decedents dying after the same date.

There are a number of changes that have been made to IRA accounts including the introduction of the Roth IRA. Contributions to a Roth IRA are not tax deductible, but future distributions of the earnings are tax free. In other words, no tax is due on withdrawal. Eligibility for a Roth IRA is phased out for single taxpayers with adjusted gross incomes between \$95,000 and \$110,000, and for joint filers between \$150,000 and \$160,000. Unlike traditional IRAs, contributions to a Roth IRA may be made even after the taxpayer reaches age 70½. Amounts from existing deductible or non-deductible IRAs may be rolled over to a Roth IRA without the early distribution penalty, unless the adjusted gross income of the taxpayer exceeds \$100,000 or the taxpayer is a married individual filing separately. Regular income tax will be due on any taxable amount rolled over from an existing IRA; however, the taxable amount will be collected over four years if the rollover occurs during 1998.

The rules for traditional IRAs also are changed. The new law allows a spouse who does not participate in an employee-sponsored retirement plan to

deduct contributions up to \$2,000 annually even if the other spouse participates in a retirement plan. This feature is phased out when adjusted gross income exceeds \$150,000.

Children's education.

The new provisions are a good news-bad news story. The bad news is that all of these benefits are phased out at various levels of adjusted gross income depending on the benefit and on whether filing a single or a joint return. The phase-out provisions vary for each provision explained and will affect married couples with income levels as low as \$80,000. The good news is that it may make sense to have these provisions exercised by members of your family with lower income.

For the first two years of a college education, taxpayers are entitled to a non-refundable tax credit of 100 percent of the first \$1,000 of qualified tuition and related expenses and 50 percent of the next \$1,000, for a total credit of \$1,500 annually. The credit (called the Hope Credit) is available to the taxpayer as well as to the spouse and dependents for expenses paid after December 31, 1997.

There also is a Lifetime Learning Credit of up to \$5,000 for qualified expenses paid for graduate and undergraduate work after December 31, 2002.

There is a provision allowing a taxpayer to contribute up to \$500 annually per child to an educational IRA. Contributions are not deductible, but withdrawals are tax free if used to pay tuition and other related educational expenses. For estate tax purposes, the contributions are eligible for the \$10,000 per donor annual gift tax exclusion. Earnings on contributions are not taxable, but any earnings not used to pay for educational expenses will be included in the gross income of the education account beneficiary and will incur a 10 percent tax penalty. The amount left in the IRA can be rolled over to a younger dependent's educational IRA before the beneficiary reaches age 30. A taxpayer cannot make contributions to an educational IRA and to a state tuition program in the same year.

In each tax year, a person can elect either the Hope Credit, the Lifetime Learning Credit, or the tax-free distribution from an educational IRA.

Finally, there also is a deduction available annually of up to \$1,000 for interest paid on educational loans.

Summary. TRA provisions affect various features of present tax and investment plans. It is important to review these provisions to maximize the positive aspects of these new rules.

NJM

100% NO LOA

T. Rowe Price Summit Funds

THE ROAD TO HIGHER YIELDS IS PAVED WITH LOWER EXPENSES



T. Rowe Price Summit Funds

Give your money more earning power with Summit Funds: six no-load, tax-exempt, and taxable bond and money market funds that offer investors an opportunity to earn more.

High yields and lower expenses

A \$25,000 minimum initial investment per fund is the reason you pay less in expenses. Summit Funds' higher account balances help us manage more cost-effectively and keep fees low. In fact, Summit Funds' fees are substantially lower than the average cost of comparable fixed income mutual funds.* All things being equal, lower expenses can provide higher yields and help you keep more of what your money earns. Of course, yield and share price will fluctuate with interest rate changes. Past performance cannot guarantee future results. Free checkwriting** No sales charges of any kind.

**Call 24 hours for a free report and prospectus
1-800-541-4742**

SUMMIT INCOME FUNDS

SUMMIT CASH RESERVES††

Current 7-day yield as of 12/2/97:

5.32%

Objective: Preserve capital and provide liquidity

Invests in: High-quality money market securities

SUMMIT LIMITED-TERM BOND

Current 30-day yield as of 11/23/97:

6.08%

AVERAGE ANNUAL RETURNS:†

1-year: **7.64%**

Since inception (10/29/93): **4.56%**

Objective: High level of current income

Invests in: Investment-grade corporate bonds

SUMMIT GNMA

Current 30-day yield as of 11/23/97:

6.55%

AVERAGE ANNUAL RETURNS:†

1-year: **9.98%**

Since inception (10/29/93): **6.68%**

Objective: Highest possible current income

Invests in: High-quality, government mortgage-backed securities

SUMMIT MUNICIPAL FUNDS

All exempt from federal income taxes***

SUMMIT MUNICIPAL MONEY MARKET††

Current 7-day yield as of 12/2/97:

3.49%

Objective: Capital preservation and liquidity

Invests in: High-quality municipal money market securities

SUMMIT MUNICIPAL INTERMEDIATE

Tax-equivalent yield 36% tax rate:

6.69%

Current 30-day yield as of 11/23/97:

4.28%

AVERAGE ANNUAL RETURNS:†

1-year: **8.31%**

Since inception (10/29/93): **6.07%**

Objective: High income

Invests in: Investment-grade municipals

SUMMIT MUNICIPAL INCOME

Tax-equivalent yield 36% tax rate:

7.69%

Current 30-day yield as of 11/23/97:

4.92%

AVERAGE ANNUAL RETURNS:†

1-year: **10.79%**

Since inception (10/29/93): **6.61%**

Objective: Highest possible income

Invests in: Long-term, investment-grade municipals

Invest With Confidence®
T. Rowe Price



†Average annual returns are for the periods ended 9/30/97 and include changes in principal value, reinvested dividends, and capital gain distributions. Investment return and principal value will vary, and shares may be worth more or less at redemption than at original purchase.

*Figures are for Taxable Money Market, Short-Term Corporate, GNMA, Municipal Money Market, Municipal Intermediate, and Municipal General Bond Fund categories, respectively, as of 9/30/97. Source: Lipper Analytical Services, Inc. **\$500 minimum. ***Some income may be subject to state and local taxes and the federal alternative minimum tax.

††These funds are neither insured nor guaranteed by the U.S. government, and there is no assurance that they will be able to maintain a stable \$1.00 net asset value. Read the prospectus carefully before investing. T. Rowe Price Investment Services, Inc., Distributor.

SUM0400

HEALTH CARE AND THE ENGLISH LANGUAGE

Bernard S. Strauss, MD

*We were
known as
physicians,
not providers.
We are the
ones who
truly
deliver
good health
care to all
patients.*

Until recently, the medical profession was held in the same high regard as members of the clergy or justices of the Supreme Court. While all of these professions were accorded great respect and admiration, doctors also were viewed as having significant political potency. If any group hoped to

challenge the status quo of physicians, it would first have to "level the playing field" and defuse the power, whether real or perceived, that the medical community might bring to any issue.

One way to achieve this "leveling" would be to demythologize the public's image of the doctor. Government and managed care have tried to accomplish this weakening of the doctor's role in society simply by changing language in an effort to change the traditional relationship between the doctor and the patient.

While this change may seem to be an unimportant factor, it is much more than just a semantic alteration because the uniquely personal relationship between the doctor and the patient is based, in part, on the

terms we employ that allow the patient to place trust in the doctor.

Why would the managed care industry want to weaken or alter this relationship? One reason may be an attempt to change the patient's loyalties from the doctor to the firm. By so doing, the patient may develop closer ties to the HMO than to the doctor.

If that transfer of loyalty takes place, the patients are no longer "our" patients, but now have become a commodity that is "owned" by the managed care organization and "may" be assigned to the physicians with the determining factor being profitability instead of a quality outcome.

One example of a significant and onerous change was when the title of "doctor" or "physician" was intentionally eliminated from all contracts and communications dealing with managed care relationships and was replaced by the term "provider." By this definition, providers also included dentists, chiropractors, therapists, nurses, and technicians. The contention and the implication was that since all of these individuals "provided" services to the patient, it would be appropriate to use one designation to cover all of them, regardless of their level of training or their degree of responsibility. The playing field was leveled in one fell swoop and the "provider" became the lowest common denominator.

A cartoon was printed recently showing a patient seated across the desk from a man in a white coat who is saying, "You're too sick to be seen by a provider; you need a doctor."

One may view the traditional bond between a doctor and a patient as a strong magnetic force holding two objects together and resisting any effort to weaken it. However, the bond can be destroyed by changing the nature of one or both of the objects.

In this vein, "doctor" becomes "provider" or "health care professional" or even "medical waste generator." A patient becomes a "member" or "covered life." The new terminology "provider-member relationship" or "health care professional-covered life relationship" does not evoke the same emotional response as does "doctor-patient relationship," the response that furthers the positive interaction between the two parties—doctor and patient.

The language we use has a direct and powerful effect on our thoughts and our attitudes, which then are reflected in our behavior.

Prior to the onset of managed care, primary care physicians had a larger measure of pride in overseeing all aspects of their patient's problems, including making appropriate referrals and ordering diagnostic tests when the only indication was the patient's welfare. The doctor was called a doctor, not a PCP or a gatekeeper.

By manipulating traditional language, the managed care industry has been able to weaken or to dissolve a critical bond—that uniquely successful relationship that had heretofore existed between the doctor and the patient. In a series of "coups de language," the business community has taken the physician, an educated, motivated, independent professional and reduced him or her to an inventory item, to be bought, sold, hired, fired, downsized, and decertified. Perhaps this is the real world, and our prior status wherein doctors could remain separate and apart from mundane considerations relating to economics and profitability was only an illusion.

However, by changing the physician's status and by lowering the esteem in which the profession was held, managed care also has destroyed that special relationship that had been, and remains, a crucial and integral factor in effecting a successful outcome.

The traditional response of the medical community to the position that society had bestowed upon it was to accept the awesome responsibility and to recognize its obligation to the welfare of its patients. Physicians, not a commercial enterprise, bring patients into the world, tend to their ills for all their days, and gently usher them out, knowing that physicians have spared nothing to prolong life and finally allow its passing with dignity.

Rather than having that traditional relationship with the patient, the doctor now is required to have a fiduciary relationship with a managed care organization that may force him or her to reduce or modify services. Guess who ultimately suffers?

If this current trend in our health care system is to be reversed, it might begin with a restoration of the traditional language from one that sounds like a business thesis to that of an earlier time when non-economic terms like compassion, sympathy, listening, touching, caring, and crying were in use. The medical profession must try to re-establish those feelings of pride and satisfaction that come with the "doctor-patient" interaction. We knew, and our patients knew, that our best efforts were put forth on their behalf, for our own "job satisfaction" and not for the bottom line. We were known as physicians or doctors, not providers. That was always the "ne plus ultra" of the art of medicine and one that has to be restored and maintained if we are to truly deliver good health care in the future.

Brain computer communication: Reading your mind

Eric J. Lerner

One of the most devastating medical conditions is total paralysis. In the "locked in" state that is the result of late-stage amyotrophic lateral sclerosis (ALS), very severe cerebral palsy (CP), or brain stem stroke, nearly all control over voluntary muscles is lost, generally only excluding the muscles of the eyes. In such conditions, any movement is impossible and communication becomes exceedingly difficult, mediated by slow and limited modes such as eye blinks.

The development of personal computer technology over the past decade has brought some help to such severely disabled individuals. In particular, optical devices can detect the direction that a patient's eyes are looking by reflecting light off them. Such detectors can be used with a computer monitor to allow the patient to select words or commands from the screen merely by looking at them. These systems, however, have their limitations and are not suitable for all people who are severely disabled.

For patients with spinal cord injury, electromyographic activity from muscles above the lesion can be used to control electrical stimulation of paralyzed mus-

cles, thus restoring useful movement by the hand and forearm in those persons with cervical lesions or walking for those with thoracic cord lesions.

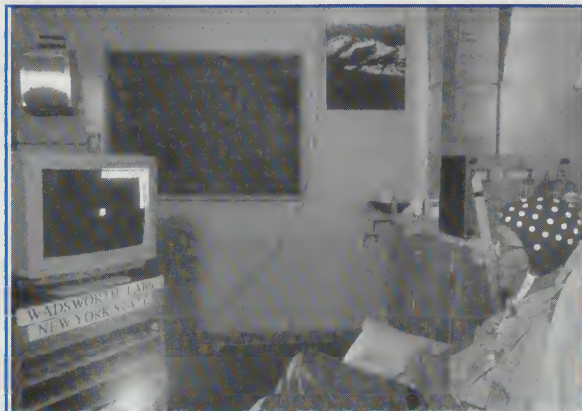
But for the most severely disabled, where ALS or CP has destroyed useful nervous control over the muscles, some new pathways of communication must be opened for speech systems and for commanding robotic arms or wheelchairs. In these cases, researchers have focused on using the brain's own electrical activity, as recorded by the electroencephalogram (EEG), as the new pathway for communication, a method termed brain computer communication.

There are three approaches to brain computer communication. The first and the simplest to implement is to use visual evoked potentials—the short responses of the brain to visual stimuli—as signals. Visual evoked potentials appear as short, easily distinguished waves occurring a fixed amount of time after a particular visual stimulus. E.E. Sutter and colleagues have designed a system to determine where a user is looking by encoding the time that a symbol flashes. An 8 x 8 array of symbols is displayed on a video screen and subgroups of symbols

alternate between red and green at a rate of 40 to 70 times per second. The response to the red-green flicker 100 ms after each shift is analyzed by computer and compared with VEP template obtained during training sessions. Responses are averaged over several alternations (less than a few seconds) and the delay between each symbol's individual flash and the evoked potential is calculated. The symbol with a response delay time matching that of the training session is selected as the symbol to which the subject is looking. In tests on normal subsets, 90 percent accuracy rates were achieved with a rate of 10 to 12 words per minute.

Evoked potential-based communication, however, has some of the same disadvantages of eye motion detection systems. The screen must be in the center of the visual field, so that communication requires full attention. This is satisfactory for verbal communication but not for the control of mechanical devices, where vision is needed to monitor what the mechanical arm or wheelchair is doing and to correct it accordingly.

A second approach, which overcomes these limitations, is based on recognizing the EEG



A test patient at the Wadsworth Center for Laboratories and Research.

patterns produced when the brain prepares to make specific movements. In work by A.B. Barrette at Florida International University as well as by other groups, EEGs were obtained from experimental subjects at four locations on the left side of the scalp. Subjects were asked to respond to visual signals to the left eye (that could not affect the left brain hemisphere) by either raising their right index finger or their right toe (controlled by the left hemisphere). The averaged signals, aligned to the time of the stimulation, were divided into 4 second slices and used as templates to compare with single test EEGs. Correlations between the test pattern and the template were used to determine if the test signal was a finger or toe response or neither. An accuracy of 90 percent was achieved.

In related work by Pfurtscheller, multiple electrodes measured the responses over sensorimotor cortex in sever-

al frequency bands of the EEG as the subject moved a joystick to the left or right. A neural network is trained to recognize the pattern associated with either movement, and then recognizes

the EEG pattern when the subject only thinks about moving the joystick. The system has about 90 percent accuracy, allowing normal subjects to move cursors in one dimension merely by thinking about moving it with their hand.

Potentially, recognizing specific motor intentions could be of great use in paralysis patients. If a computer could be trained to recognize a wide variety of such patterns, robotics' arms could be used to move in response, or even to move the subject's own limbs in response to intentions.

A third approach involves training the subjects to control their own EEG, rather than training a computer to correctly interpret the EEG. In work by Jonathan Wolpaw of the Wadsworth Center for Laboratories and Research and Dennis J. McFarland of the State University of New York, in Albany, subjects are trained to alter the mu rhythm of their EEG, the fre-

quency component from 8-12 Hz. Normal experimental subjects had separate electrode pairs on each side of their head, yielding two sets of EEGs, filtered to measure the amplitude of the mu rhythm. A cursor on a computer screen moved in response to the subject's EEG and the subject tried to get the cursor to hit a series of "targets" that were quadrants of the edge of the screen. If the cursor moves off the screen on the target, it was a hit; if it moved off anywhere else, it was a miss. Over a six-to-eight-week training period, four of five subjects were able to gain control of the cursor, by influencing their mu rhythms. These subjects were able to hit in 60 to 70 percent of times, as compared with the 25 percent expected by chance, at rates of 15 to 30 times per minute.

While these techniques have not yet been tested on disabled patients, the research gives hope that such systems, perhaps simultaneously training computer and human subjects to respond correctly, could lead to a good level of patient control over such prosthetic aids as robot arms or wheelchairs, giving severely paralyzed patients the ability to move and communicate with relative ease. The link between their brains and the outside world will be a computer, rather than their own bodies.



Department of Medicine
presents
case presentations and workshop on

MEDICAL ETHICS
Physician Assisted Suicide
Death and Dying
A Medical Provider Controversy

Wednesday, February 4, 1998 • 8:30 a.m. to 12:00 noon
Lecture Hall B, 2nd Floor, College Building
15th between Race & Vine, Philadelphia, PA

8:30 Grand Rounds Co-Moderators: Jeffrey Glassroth, M.D.
Allan B. Schwartz, M.D.

Physician Assisted Suicide: Last Rite or Last Rights?
Professor Alan Meisel, Esquire
Professor of Bioethics and Law
University of Pittsburgh School of Law and Center for Medical Ethics

9:30 Case Presentations
Moderator and Workshop Director: Allan B. Schwartz, M.D.

- Morphine Drip for Intractable Pain
- Withdrawal from Life Support Care
- Non-Heart Beating Organ Donation
- DNR Orders, Medical Facility
- Surrogate Decision Making
- Living Will, Advance Directives

Panel Discussants
Robert Promisloff, D.O.
Paul Solnick, M.D., J.D.
Constance Perry, Ph.D.

Priscilla Denham, M.Div.
Janet Fleetwood, Ph.D.
Kelly A. Beaudin, Esquire
Brenda A. Walter, Esquire

12:00 Adjourn

All health care workers are invited. Physicians, nurses, psychologists, social workers, administrators, clergy, and lawyers.

Full Disclosure Statement: All faculty participating in continuing medical education programs sponsored by Allegheny University of Health Sciences, MCP♦Hahnemann School of Medicine are expected to disclose to the audience any real or apparent conflict(s) of interest related to the content of their presentation.

For course information call: 215-762-8695.

Registration information for those desiring a CME certificate call 215-762-8263.

Fee: \$15.00 (AUHS/CME)

Accreditation: Allegheny University of the Health Sciences, MCP♦Hahnemann School of Medicine is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education programs for physicians. MCP♦Hahnemann School of Medicine designates this educational activity for a maximum of 3.5 hours in category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

JANUARY AND FEBRUARY '98

Head and Neck Oncology

January 14, 1998
The Manor, West Orange
AMNJ, 609/275-1911

Diagnosis & Management of HIV/AIDS

January 15, 1998
Carrier Foundation, Belle Mead
AMNJ, 609/275-1911

Ob Ultrasound

January 15, 1998
JFK Medical Center, Edison
AMNJ, 609/275-1911

Radiological Society

January 15, 1998
UMDNJ-RWJ Med Sch
732/235-7721

Perinatal Ultrasound Symposium

January 17-18, 1998
Hyatt Regency, New Brunswick
UMDNJ, 732/235-7430

Diuretic Therapy in Renal Insufficiency/Nephrotic Syn.

January 20, 1998
Overlook Hospital, Summit
AMNJ, 609/275-1911

General Internal Medicine

January 20, 1998
UMDNJ, New Brunswick
732/235-7430

Society of Anesthesiologists

January 20, 1998
Forsgate Country Club, Jamesburg
609/275-0083

Child Sexual Abuse/Neglect

January 21, 1998
Warren Hospital, Phillipsburg
AMNJ, 609/275-1911

Interhospital Endocrine Rounds

January 21 and 28, 1998
University Hospital, Newark
973/982-6170

Radiology Visiting Professor Lecture

January 22, 1998
St. Barnabas Medical Center, Livingston
973/533-5805

Medical Grand Rounds

January 28, 1998
VA Medical Center, East Orange
973/982-6170

Gastroenterological Society

February 1998
St. Barnabas Medical Center, Livingston
AMNJ, 609/275-1911

Endocrinology Visiting Professor Lecture

February 4, 1998
VA Medical Center, East Orange
973/676-1000 x1311

Interhospital Endocrine Rounds

February 4, 11, 18, and 25, 1998
University Hospital, Newark
973/982-6170

Medical Grand Rounds

February 4, 11, 18, and 25, 1998
VA Medical Center, East Orange
973/982-6170

Dermatological Society

February 10, 1998
Location to be announced
AMNJ, 609/275-1911

Women & HIV/AIDS

February 10, 1998
South Jersey Hospital, Elmer
AMNJ, 609/275-1911

General Internal Medicine

February 17, 1998
UMDNJ, New Brunswick
732/235-7430

*Have you recently moved?
Please notify us of
your address change.*

Name: _____

New address: _____

City _____ State _____ Zip _____

**Please send to:
New Jersey MEDICINE**

2 Princess Road
Lawrenceville NJ 08648
FAX 609/896-1368
e-mail info@MSNJ.org

June 8-12th, 1998

Update Your Medicine twenty-fourth annual practical CME course with lectures, workshops, and Meet-the-Professor luncheons. Sponsored by Cornell University Medical College in New York City and the Association of Practicing Physicians of The New York Hospital. 37.25 Category 1 AMA-PRA credit. Additional 11½ credits available for Hands-on Workshops. This program has also been reviewed and is acceptable for 37.25 prescribed hours by the American Academy of Family Physicians. Information: Lila A. Wallis, MD, Director and Debora A. Laan, Coordinator, 445 East 69th Street, Olin-Room 328, New York, NY 10021. Telephone: 212-746-4752.



Specializing in the Business of Health Care

Physician Practice Assessment/Contract Negotiations/
Litigation Support/
New Practice Set-Up/Group Practice Formation/
Physician Income Distribution

RD HUNTER & COMPANY LLP

Certified Public Accountants and Consultants

Princeton Paramus New York City
Call us at 800-235-9381

INTERNATIONAL COLLEGE OF ACUPUNCTURE & ELECTRO-THERAPEUTICS

(Permanently Chartered by the University of the State of New York,
State Education Department)

1998 Seminars & Workshops & 14th Int. Symposium ACUPUNCTURE & ELECTRO-THERAPEUTICS in Clinical Practice

25 credit hours can be earned by attending
one three-day weekend (Friday-Sunday) session 9 am-7 pm

Jan. 16-18, 1998

Feb. 13-15, 1998

Mar. 13-15, 1998

May 15-17, 1998

June 19-21, 1998

Holiday Inn, Manhattan

440 W. 57th St, NYC between 9 & 10 Ave.

Hotel 212-581-8100 during meetings

14th Annual International Symposium, Oct. 22-25, 1998 the School of Int'l Affairs, Columbia University

In addition to holding 7-8 seminars & workshops per year, the International College of Acupuncture & Electro-Therapeutics organizes an Annual International Symposium every October at the School of International Affairs, Columbia University, NYC and publishes *Acupuncture & Electro-Therapeutics Research*, *The International Journal* quarterly, through Cognizant Communications and is listed by 15 major international indexing periodicals (*Index Medicus*, *Current Content*, *Excerpta Medica*, etc.), is recognized as a major leading journal in the field. The most prestigious and internationally recognized, "Fellow of the International College" (F.I.C.A.E.) will be awarded to members of the College who present a minimum of 2 original research papers during the annual International Symposium and publish them in the official journal, or who have made significant contributions in the field.

These seminars & workshops train physicians and dentists in the latest theories and techniques of manual & electro-acupuncture, TENS & simple non-invasive diagnostic methods (including cardiovascular, neuro-muscular, central nervous systems & Bi-Digital O-Ring Test).

For information, contact Dr. Y. Omura, MD, ScD, FICAE, 800 Riverside Drive (8-I), NY, NY 10032; 212-781-6262, Fax 212-923-2279 or Dr. Richard Simon, PhD, 212-662-7022 or Ms. Sandra Beckman, MA, 212-679-8986. All ICAE meetings are accredited by the New York State Boards for Medicine and Dentistry toward the 300 accredited hour requirement for the Acupuncture Certificate in New York State. Also eligible for AMA/CME Category I credit. MSSNY designates this CME activity for AMA/CME Category I credits toward Physician Recognition Award.

Our unique approach to malpractice insurance can improve your cash flow.

Most New Jersey malpractice insurance policies require you to purchase a reporting endorsement — known as a tail — to protect against claims that may occur during retirement. B.C. Szerlip offers a unique policy from an A+ rated company that does not include an annual tail premium. In fact, if you maintain coverage with us until retirement, you'll *never* have to purchase a tail, and you'll still be protected.

That's just one example of the creative ways that B.C. Szerlip has discovered to help doctors with their long-range financial planning.

At B.C. Szerlip, we take a big-picture view of your practice, offering you comprehensive insurance and financial planning services. You can benefit from our nearly two decades of experience providing malpractice insurance for medical offices both large and small. In addition, our financial planners can offer strategic guidance for the overall health of your business affairs, so you can stay focused on the health of your patients.

We'd like to give you a taste of our full-service approach by sending you *The Managed Care Survival Kit for Physicians*. To receive your complimentary copy of this useful guide, please call us at 800-684-0876.

BCSZERLIP INSURANCE AGENCY INC.

99 WOOD AVENUE SOUTH, PO BOX 217
ISELIN, NJ 08830-0217
800-684-0876 • 732-205-9800
FAX: 732-205-9496
E-MAIL: bcszerlip@aol.com

*Professional Insurance Services
for Health Care Providers*

FEBRUARY AND MARCH '98

Radiology Society Monthly Meeting

February 19, 1998
Location to be announced
973/533-5805

Radiology Visiting Professor Lecture

February 26, 1998
St. Barnabas Medical Center, Livingston
973/533-5805

Oncology Society Clinical Abstract Meeting

March 3, 1998
The Manor, West Orange
AMNJ, 609/275-1911

Endocrinology Visiting Professor Lecture

March 4, 1998
VA Medical Center, East Orange
973/676-1000 x1311

Interhospital Endocrine Rounds

March 4, 11, 18, and 25, 1998
University Hospital, Newark
973/982-6170

Medical Grand Rounds

March 4, 11, 18, and 25, 1998
VA Medical Center, East Orange
973/982-6170

Head and Neck Oncology

March 11, 1998
The Manor, West Orange
AMNJ, 609/275-1911

Vascular Society Annual Meeting

March 11, 1998
Cooper Hospital, Camden
AMNJ, 609/275-1911

General Internal Medicine

March 17, 1998
UMDNJ, New Brunswick
732/235-7430

How Much Peritoneal Dialysis is Enough?

March 17, 1998
Overlook Hospital, Summit
AMNJ, 609/275-1911

Imaging of Primary Small Bowel Pathology

March 18, 1998
Cooper Hospital, Camden
609/342-2383

Pregnant Women with HIV/AIDS

March 18, 1998
Union Hospital, Union
AMNJ, 609/275-1911

Radiological Society Monthly Meeting

March 19, 1998
UMDNJ-RWJ Med Sch
973/533-5803

Society of Anesthesiologists Meeting

March 20-22, 1998
Trump Plaza Hotel & Casino
609/275-0083

TB Management of HIV-Infected Patients

March 24, 1998
South Jersey Hospital, Elmer
AMNJ, 609/275-1911

Academy of Otolaryngology

March 25, 1998
PNC Arts Center, Holmdel
AMNJ, 609/275-1911

Radiology Visiting Professor Lecture

March 26, 1998
St. Barnabas Medical Center, Livingston
973/533-5805

232nd MSNJ Annual Meeting

April 28-May 2, 1998

Trump Taj Mahal
Casino/Resort
Atlantic City

1-800-825-8888

HOUSING APPLICATION

232ND ANNUAL MEETING MEDICAL SOCIETY OF NEW JERSEY

APRIL 28-MAY 2, 1998

TRUMP TAJ MAHAL CASINO/RESORT

1000 BOARDWALK AT VIRGINIA AVENUE, ATLANTIC CITY, NJ 08401

RESERVATION DEPARTMENT 1-800-825-8888

(Please Print)

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Sharing With _____

Date of Arrival _____ Time _____

Date of Departure _____ Time _____

A one-night deposit (equivalent to room rate) is required with all reservation requests. Please send check or money order payable to the **TRUMP TAJ MAHAL CASINO/RESORT** or complete the following:

Card # _____ Type _____ Exp. Date _____

SCHEDULE OF RATES SUBJECT TO 12% TAX, PLUS \$2 PER ROOM, PER NIGHT

() SINGLE \$118.00 () DOUBLE \$118.00 EXTRA PERSON \$25.00

Reservations must be received prior to MARCH 30, 1998.

() One-Bedroom Suite \$275.00 per day () One-Bedroom Hospitality Suite \$350.00 per day

Check-out time is 12 Noon. Rooms may not be available for check-in until after 4 p.m. Check-in time on Sundays is 6 p.m. FORTY-EIGHT (48) HOURS NOTICE OF CANCELLATION is required for a full refund. PARKING: There is a state-imposed \$2.00 minimum charge per 24-hour period for each motor vehicle parking on the premises.

() Check if Official Delegate _____ County _____

PLEASE NOTE: Current state sales tax is 3% and occupancy tax is 9%, and room usage fee is \$2.00 per room, per night. These taxes are subject to change, without notice.

The proceeds from the fees collected shall be paid into a special fund which will be established and held by the Atlantic City Convention Center Authority. Amounts in the special fund shall be expended by the Convention Center Authority solely for the purposes of promoting tourism, conventions, resorts and casino gaming.

MAIL THIS APPLICATION TO: Reservations
Trump Taj Mahal Casino/Resort
1000 Boardwalk at Virginia Avenue
Atlantic City, NJ 08401

Housing Application online at www.msnj.org

THE MEDICAL SOCIETY OF NEW JERSEY CLASSIFIED ADVERTISEMENT INSERTION REQUEST

RATES (Placement in New Jersey *MEDICINE* OR on WEB Site)

<http://www.msnj.org>
WEB Site

New Jersey *MEDICINE*

Per Month—Non-Members

Minimum 45 words	\$ 45.00
plus each word over 45 words	\$ 1.00

Per Month—Members

Minimum 45 words	\$ 30.00
plus each word over 45 words	\$ 1.00

Per Month—

Minimum 45 words	\$ 45.00
plus each word over 45 words	\$ 1.00

(Placement in New Jersey *MEDICINE* AND on WEB Site)

<http://www.msnj.org>
WEB Site

New Jersey *MEDICINE*

Per Month—Non-Members

Minimum 45 words	\$ 45.00	\$ 36.00
plus each word over 45 words	\$ 1.00	\$.80

Per Month—Members

Minimum 45 words	\$ 30.00	\$ 36.00
plus each word over 45 words	\$ 1.00	\$.80

PREPARE YOUR COPY ON A SEPARATE PAGE AND ATTACH TO THIS ORDER FORM

INSERTION AUTHORIZATION

Name _____ MSNJ Member? Yes _____ No _____
 Company _____ Telephone Number _____
 Address _____ Fax Number _____
 City _____ State _____ ZIP _____
 New Jersey *MEDICINE* Issues _____
 Web # of 30 Day Insertions _____

New Jersey *MEDICINE*

Non-Member	
Minimum 45 Words	\$ 45.00
+ Each Add'l Word @\$1.00	\$ _____
Per Issue	\$ _____
X Number of Issues	
AMOUNT DUE	\$ _____

New Jersey *MEDICINE*

Member	
Minimum 45 Words	\$ 1.00
+ Each Add'l Word @\$1.00	\$ _____
Per Issue	\$ _____
X Number of Issues	
AMOUNT DUE	\$ _____

MSNJ WEB SITE

Non-Member or Member	
Minimum 45 Words	\$ 45.00
+ Each Add'l Word @\$1.00	\$ _____
Per Month	\$ _____
X Number of Months	
AMOUNT DUE	\$ _____

**MSNJ WEB SITE WITH
NEW JERSEY *Medicine* Placement**

Non-Member or Member	
Minimum 45 Words	\$ 1.00
+ Each Add'l Word @\$.80	\$ _____
Per Month	\$ _____
X Number of Months	
AMOUNT DUE	\$ _____

TOTAL DUE \$ _____ ALL CLASSIFIED ADS MUST BE PRE-PAID
 Please make check payable to "Medical Society of New Jersey"

Mail to: Classified Ad Department
 370 Morris Avenue
 Trenton, NJ 08611

Tel: 609-393-7196
 Fax: 609-393-3759

I'm on the MSNJ Physician Finder. Are you?



*Carl Restivo, Jr, MD
MSNJ President*

The Physician Finder:

- Showcases and markets my practice.
- Offers a comprehensive overview about my office.
- Presents detailed information for referrals.

The MSNJ Physician Finder is an electronic directory of active MSNJ members. You can find the Physician Finder on MSNJ's web site:

www.msnj.org

For more information about the Physician Finder
call MSNJ, 609/896-1766 ext. 259.

The **MSNJ Physician Finder** is the place to turn
for information about MSNJ physicians.

CLASSIFIED ADS

100 OPENINGS PHYSICIANS (MULTIPLE SPECIALTY LISTINGS)

PHYSICIANS

Physicians: Work independently as a mobile insurance examiner. Great \$/case. Set own hours. Quality company seeks MDs to perform insurance physicals in Bergen Co. and vicinity. IM, FP or ER preferred. Permanent state license and personal malpractice insurance required. Fax resume to (212) 889-9640.

THE PODELL MEDICAL CENTER

New Providence Holistic Health Center: Seeking collaboration from well-trained physicians from all specialties. Especially Women's Health: also Pediatricians or Family Physicians to help develop program for A.D.D. children. Contact Dr. Podell 908-464-3800 or fax 908-464-3078.

110 OPENINGS PHYSICIANS

BC/BE INTERNISTS— OCEAN COUNTY

Busy four physician multi-specialty group welcomes CVs from highly qualified BC/BE internists. Our newly renovated diagnostic lab and office is located in the Southern New Jersey shore area. We offer a competitive salary/benefit package and group-paid full coverage malpractice insurance. Please send CV to: Medical Associates of Ocean County, P.A., 53 Nautilus Drive, Suite F, Manahawkin, NJ 08050.

200 PRACTICE FOR SALE

ORTHOPAEDIC PRACTICE

Active Orthopaedic Practice For Sale—NE NJ (Suburban NYC Area)—in 1998. Differed financial incentives available for new Orthopaedist. Write: POB 4724, Clifton, NJ 07015.

300 OFFICE RENTALS AND LEASES

ATLANTIC CITY/ BRIGANTINE AREA

Medical Facility for Lease. Modern 6000 sq. ft., one story, walk-in medical center. Ample parking. Fully equipped physical therapy, lab, on-site x-ray and trauma center for non-life threatening emergencies. Large waiting room, business center and 12 exam rooms. Ideal for multi-specialist group, managed care and occupational medical facility. Additional equipment includes AT&T Merlin telephone system, file cabinets, EEG, EKG, defibrillators, whirlpool foot baths, electric exam tables, furnishings and more. A must-see facility. Long-term lease only. Possible city and casino contracts available. Atlantic City/Brigantine area. Call Mr. D'Annunzio 609-266-4000.

EDISON

Office Space—Edison Medi-Plex Building opposite J.F.K. Hosp. Fully equipped, turn key. Rent: day, half day, night. (732) 494-6300.

HILLSBORO

Hillsboro Medical Office—1,500 sq. ft. \$1,200/mo. Busy location. Active practices in building. Ideal for new or 2nd practice. Call Dr. Wolinsky 212-476-7789 days or 215-860-8491 eves.

MILLBURN

Medical Arts Building, Millburn Avenue. Fully equipped, turn key. Rent day, 1/2 day, night. Call 973-376-8670.

RARITAN, SOMERSET COUNTY

Medical Office Space Available For Rent, Raritan, Somerset County. Two examination rooms in beautiful modern office. Great second or starter location. Shared Expenses. Call Dr. Markowitz, (908) 429-0442.

310 OFFICES TO SHARE

FORT LEE (BERGEN COUNTY)

Established 15 yr. Chiropractic Practice—Interested in sharing a 1600 Sq. Ft. spacious, modern office with 5 treatment rooms. Located in a residential area of Fort Lee—5 minutes from G.W.B. Turnkey Operation. (201) 886-8755.

MILLBURN

Sublet or Join Us. Excellent Opportunity. Active Pain Mgmt. Center has very desirable modern, lge, office space in Millburn. (5 Rms) Beaut. Waitg. Rm., etc. To sublet please have Rheumatologist, or Internist/Nutritionist join with practice. Call 201-912-4333. Mon-Friday 9-5. Saturday 9-12.

325 MEDICAL BUILDING FOR SALE OR LEASE

LAWRENCEVILLE

2300 sq. ft. Condominium Professional Building. Close to Rt. 1 corridor. Four exam rooms, consultation rooms. Large work areas. Wheelchair accessible bathroom. Two lab rooms. Lounge, storage space built-in. File room. Private entrance in rear. Purchase or Lease, daytime between 9:00 a.m. and 3:00 p.m. 609-896-0242.

340 REAL ESTATE HOME/OFFICE

MERCER COUNTY

Free standing office, approx. 2,000 sq. feet. exam rooms plus X-Ray room and PT room. Private Dr.'s office, waiting and reception area. 2 acres professionally landscaped with ample parking. Fully equipped and ready for practice. \$300,000 for this turnkey opportunity. 609-890-9009.

610 BOOKS

MEDICAL INTERNET

"Doctor's Directory of Medical Addresses: 1997/98, by Heuston and Gainey, M. Published by The Value Network, in cooperation with Heuston Consulting Inc. Provides over 900 medical Internet addresses in various index lists, including Internet domain Medical LOC and ABMS codes. Information about chaos on the Web, search engine and need for standardization. Phone order \$20.00 (includes S/H), plus NJ sales tax (\$1.20) for NJ residents. Telephone HCli 732-542-0047. Make check payable to M. Heuston, and mail to HCInc, 1 Main Street Suite 217, Eatontown, NJ 07724-3414. Credit card orders, \$20.00 plus \$3.00 S. AZ residents add \$2.00 sales tax. Telephc 1-800-576-1241, or mail to TVN, PO Box 13330, Scottsdale, AZ 85276-3330.

Medical Manager

Practice Management Software

A fully integrated practice management solution

Over 16 years' experience in providing healthcare automation solutions

Provides an open system architecture and flexibility for specialized needs

Designed for small group practices to large Integrated Delivery Systems

Overwhelming national presence

Learn more about how Medical Manager Corporation and The Medical Manager system can meet your needs. Contact us at 800.677.7784, 201.808.0088, or www.medicalmanager.com.

**Medical
Manager**

Corporation

RTI, Inc. and Medix

Empowering the Industry Through Partnership

HOSPITALISTS

A 355 bed community hospital in central New Jersey is seeking BC/BE Internal Medicine/Family Practice physicians for exciting new positions as "Hospitalists". Responsibilities include clinical inpatient care, resident teaching, and limited clinical outpatient care. Excellent suburban location near NYC. Competitive salary and benefits.

For more information call: (908) 685-2487
or fax CV to (908) 704-0083

EMERGENCY PHYSICIANS

Emergency Physician Associates is seeking quality ED physicians for a variety of practice opportunities in NJ, PA, MD and NC. We offer physicians competitive compensation, flexible schedules, malpractice insurance, a variety of practice settings, and supportive Medical Directors.

Interested candidates may call

1-800-848-EPA-1.

Here's what we are covering in February 1998

⇒ Why are home medical tests increasing in popularity?

Medical writer Sheila Smith Noonan reports on the growth of the home medical tests and collection kits industry; sales of the products reached close to \$1 billion last year.

⇒ Is Ocean County an environmentally safe place?

Dr. Elin Gursky, senior assistant commissioner, Public Health Protection and Prevention Programs, DHSS, explains the steps taken to address the health of the population in Ocean County.

⇒ What is the SANE program and is it working?

A pilot program in Monmouth County is working to improve the quality of forensic evidence collected and to promote a more sensitive and supportive atmosphere for survivors of sexual assault.

⇒ How is osteopathic medicine coping with managed care?

In a provocative point counterpoint, Drs. Joel Ross and Joshua Shua-Haim reveal their thoughts on common types of abuse and neglect suffered by senior citizens.

⇒ How are medical group managers helping today's medical practices?

Jane F. Rider, of the Medical Group Management Association, reviews the important role of group managers as they help run efficient and cost-effective medical practices.

⇒ Who is waging war against tuberculosis?

Lee B. Reichman, MD, MPH, of the National Tuberculosis Center has created educational strategies and promoted treatment efforts that result in cure rates as high as 97 percent.

⇒ Tune in for Mailstop, F.Y.I., Newsmakers, Editor's Desk, Online MSNJ, and Calendar.

We know that practicing medicine is your primary concern.

The professionals at Healthcare Management Partners will take away the time-consuming administration and pressures of billing, collections, follow-up, office management, and system maintenance, so you can concentrate on doing what you do best - practicing medicine.

Contact Rosalie Fox or Robert Rahl at 609-734-0443 to find out more.

**Practice Assessments • Billing & Collection •
MIS Systems • Group Practice Formation •
Practice Management • Income Distribution**

**Endorsed Computerized Billing,
Accounts Receivable and
Information Management Company of the
Medical Society of New Jersey**



HEALTHCARE MANAGEMENT PARTNERS

PARTNERS IN PROFIT

200 Canal Pointe Boulevard • Princeton, NJ 08540-5998
609-734-0443 • FAX 609-243-9799

A Division of Health Information Consulting Services, Inc.

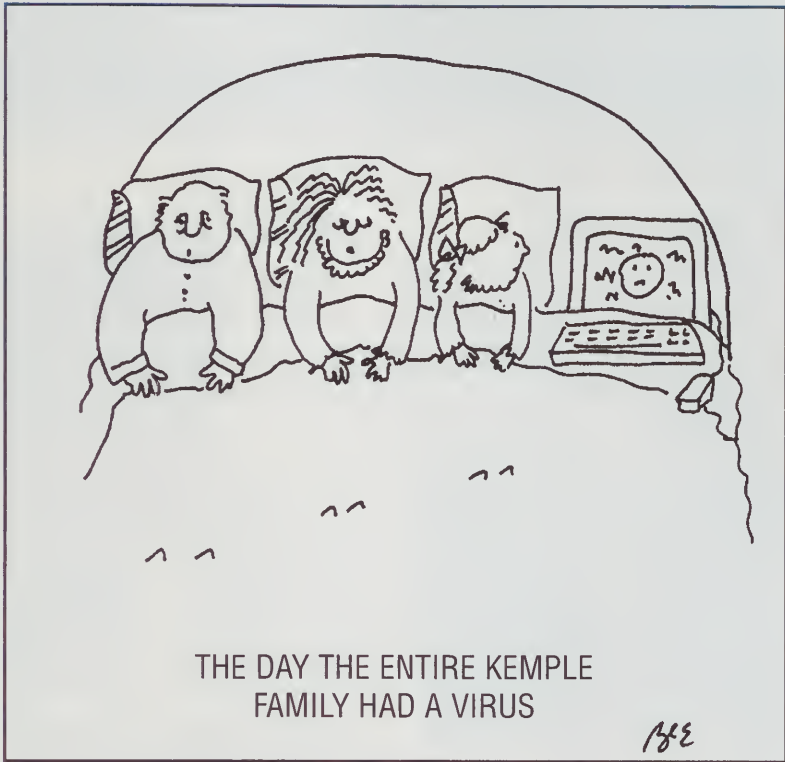
continued from page 72

The physician and the workplace

On the leading edge of health care policy and regulation, MSNJ is the recipient of a grant from The Robert Wood Johnson Foundation. MSNJ will convene the New Jersey Commission on the Physician Workforce, under the direction of Robert L. Pickens, MD, chair of the Commission and the vice-chair of the MSNJ Committee on Bio-

medical Ethics.

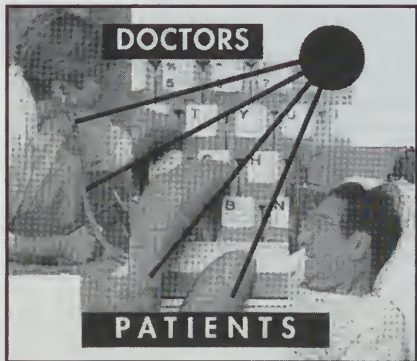
With input from the physician community and from national and state experts, the Commission will develop a report that will present a framework for a comprehensive, realistic approach to physician workforce issues that would maximize productivity, quality, and fairness in professional opportunities and access in health care in New Jersey.



One-year anniversary for www.msnj.org

There is traffic, but there is no traffic jam! Celebrating its anniversary on the world wide web, the MSNJ web site (www.msnj.org) has been growing steadily since its inception one year ago. The increased usage stems from physician members obtaining information about the state society, health care professionals requesting data about MSNJ policies, publications, and physicians, and the public accessing the Physician Finder—the only web site that offers the public a chance

to get to know MSNJ members in depth. So, don't be left out of the information high-

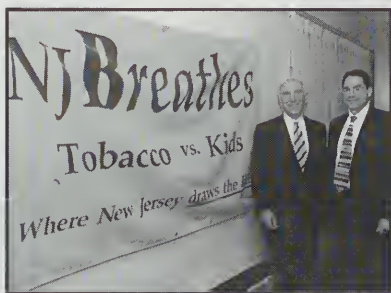


way; the traffic will pass you by. Log on to www.msnj.org and find out how MSNJ is serving the citizens and the professionals of New Jersey.

NJM

TOBACCO VS. KIDS: WHERE NJ DRAWS THE LINE

Senator Frank R. Lautenberg and Larry Downs, project director of the New Jersey Breathes, attended a recent meeting



Larry Downs (right) and Senator Frank Lautenberg discuss tobacco control.

to discuss tobacco control initiatives. Senator Lautenberg is sponsoring legislation that would increase federal tobacco taxes. New Jersey Breathes is advocating an increase in the state tobacco tax.

Senator Lautenberg, noting the powerful effect of price increases in reducing tobacco use among children, said, "New Jersey Breathes' tax initiative at the state level does not compete with, but rather complements, our efforts at the federal level." New Jersey Breathes is an independent tobacco control coalition convened by MSNJ.

MSNJ and AMA: Setting standards for performance

MSNJ announces the American Medical Accreditation Program (AMAP), a program that promises to be the one source for national, standardized, physician quality information. Through MSNJ's subsidiary, the Medical Review and Accrediting Council, Inc. (MRAC), MSNJ has partnered with the AMA to set standards for the performance of practicing physicians. AMAP is a voluntary, comprehensive accreditation program that measures and evaluates individual physicians in five areas: credentials, personal qualifications, environment of care, clinical performance, and patient care results.



Joseph Sokolowski, MD

"AMAP is the new national benchmark for physician quality. MSNJ urges all physicians to participate in AMAP. It's good for physicians, our patients, and the whole health care system," explains Joseph Sokolowski, MD, chair of MRAC. Contact Kurt Hoenigsberg at MSNJ at 609/896-1766, extension 264, for a special introductory offer for members.

Tri-county focus on women's health

The Hudson County Medical Society in association with the Bergen County Medical Society and the Essex County Medical Society hosted a joint meeting centered on women's health care issues. Speakers included MSNJ past-presidents Palma E. Formica, MD, and Anthony P. Caggiano, Jr, MD; Susan C. Reinhard, RN, PhD, deputy commissioner, Senior Services, Department of Health and Senior Services; Ruth J. Schulze, MD, Board of Trustees, Bergen County Medical Society; and Assemblywoman Joan M. Quigley.



Doctors Nancy Mueller, Ruth Schulze, Anthony Caggiano, and Palma Formica

continued on page 71

New Jersey MEDICINE

Health Care in the Garden State

February 1998

REPORT CARDS
OR HMOs
DOCS REACT TO
MANAGED CARE
OUTLIGHT
TB
DEAN COUNTY
HEALTH CHECK

TEXAS MEDICAL ASSOC. LIBRARY

FEB 24 1998

AUSTIN, TEXAS



Texas Medical Assoc
Journal Office
401 West 15th St
Austin, TX 78701

Home medical tests:
Do they measure up?

Y - O - U - R

PRACTICE

MADE MORE

PERFECT

WITH OVERHEAD EXPENSE INSURANCE FROM BLANKSTEEN

If you get sick, we'd like to help keep your practice well with overhead expense coverage that can reimburse office salaries, rent, insurance premiums, and utilities during an extended disability. Your needs are special, so call and talk with us. The only time to draw a blank in your insurance is when you fill it in with Blanksteen.



The _____ steen Companies

The Blanksteen Companies 253 Washington Street Jersey City, NJ 07302 201-333-4340 1-800-BLANK-AG
The Blanksteen Companies 161 William Street New York, NY 10038 212-732-9435 1-800-BLANK-AG
The MEDICAL SOCIETY OF NEW JERSEY endorsed plans, including Professional Overhead Expense underwritten by National Casualty Company.

FEB 24 1998

AUSTIN, TEXAS

newsWATCH

"NJ KidCare"—New Jersey's new \$136-million Title XXI plan—will expand health care coverage among 100,000 children in low-income families in two ways.

First, families with incomes up to 133 percent of the federal poverty level will become eligible for Medicaid. Second, comprehensive managed care benefits will reach families up to 200 percent of the poverty level.

NJ KidCare was designed by the state Department of Human Services, which previously devised a landmark system using a neutral enrollment broker and an external quality assurance reviewer to prevent abuses in Medicaid managed care.

On the national level, adoption of the State Children's Health Insurance Program, together with the "unexpected coalescence of liberal and conservative forces that produced it," was rated the top health story of 1997 by *Medicine & Health*. For gutsy leadership in getting the program enacted, Utah's Republican **Senator Orrin Hatch** was named Health Person of the Year. Runner-up was Mississippi's Democratic **Attorney General Michael Moore**, chief engineer of the tobacco settlement.

The Medical Society of New Jersey (MSNJ) succeeded in its nationally tracked effort to force leadership changes and reform upon the AMA. Leaders of MSNJ praised the selection of **Lynn E. Jensen, PhD**, as AMA interim executive vice-president and permanent chief operating officer. Jensen succeeds the Sunbeam-tarnished **P. John Seward, MD**.

Who are the uninsured, anyway? Research by Agency for Health Care Policy & Research

(AHCPR) economists **Philip F. Cooper** and **Barbara Steinberg Schone**, reported in *Health Affairs'* year-end managed care issue, reveals that the ranks of the uninsured consist increasingly of families of workers who decline an employer's offer of health benefits. Most notably, among workers younger than age 25, the insurance "take-up rate" fell from 87 to 70 percent between 1987 and 1996.

The same *Health Affairs* issue contains consultant **Lynn Etheredge's** proposal *du jour* to create a five-person National Health Care Market Commission, modeled on the Securities & Exchange Commission, to standardize information and protect consumers.

A team of AHCPR-funded economists led by **Robert A. Connor** report that hospital mergers between 1986 and 1994 led to average price reductions of 7 percent. The declines were twice as great in areas with high HMO penetration, a finding that reinforces the merger trend now dominating the hospital landscape in New Jersey.

Indeed, the same issue offers additional evidence that HMOs steer patients toward low-price hospitals, regardless of quality considerations. HMO enrollees in southeast Florida were not especially likely to obtain coronary artery bypass surgery in low-mortality or high-volume hospitals, say RAND researcher **Jose J. Escarce** and colleagues.

In HMOs' defense, though, the previous *Health Affairs* issue presented meta-analysis findings by **Robert H. Miller** and **Harold S. Luft**, later summarized in the *Healthcare Leadership Review*, that HMO enrollees are not deprived of the high-quality care obtained by fee-for-service beneficiaries.

Even hospital lawyers are finding fault with a recently published New Jersey Supreme Court decision permitting a hospital to use the medical executive committee to review physicians for recredentialing and to hear appeals from recredentialing denials. This combining of investigative, prosecutorial, and adjudicative functions was struck down by a lower court, then reinstated by the state high court.

Hospital Law Newsletter comments that the high court expresses a confidence in committee objectivity "that is not easily justified." Adds the commenter: "It would appear that allowing the hearing to be conducted by persons previously exposed to a one-sided presentation of evidence by one of the two parties participating at the hearing is a very poor idea, although not constitutionally flawed."

Functions also are combined at New Jersey's state Board of Medical Examiners (BME), where deputy attorneys general write the regulations and rules under which physicians are disciplined, oversee investigations, prosecute cases, serve as counsel to BME, and write orders to licensees under review.

In clinical news, "unwarranted laboratory testing of patients in hospital intensive care units continues to be a problem," declares AHCPR.

An APACHE III (APACHE: the Acute Physiology and Chronic Health Evaluation tool, classifies critical care patients to facilitate outcomes research) study led by **Jack E. Zimmerman, MD**, of The George Washington University Medical Center, summarized in AHCPR's *Research Activities*, found that over-testing exposed critical care patients, especially in teach-

ing hospitals, to greater risk of anemia and greater need of blood transfusions. Moreover, a lack of blood conservation measures caused blood loss to be about one-third higher than necessary among all patients.

Disease management is touted by futurist **Leland Kaiser, PhD**, in a presentation summarized in the *Healthcare Leadership Review*. Health professionals will become "environmental ecologists" and part of an "information profession" in an era when disease is perceived "as a choice to be avoided," says Dr. Kaiser.

AMA health law director Edward B. Hirshfeld and Gail H. Thomason take a new look at determinations of medical necessity in an article in *Health Matrix*, published by the Case Western Reserve University School of Law. The authors note that third-party payers view minimal care as optimal care. They call for applying the tort of bad faith insurance settlements to health plans to prevent defrauding patients of benefits.

More broadly, though, efforts to force third-party payers to reimburse high levels of care may flounder on the shoals of economics. A likely scenario is that affluent patients will contract for an enhanced array of benefits, while poorer and uninsured patients will obtain only minimal benefits.

Are Americans willing to pay more for a greater choice of providers? The Center for Health System Change, reporting its survey findings in a *Data Bulletin*, uncovered a sharp division. Affluence indeed was associated with a greater willingness to pay more for expanded choice. Older adults, too, were especially likely to state that they would pay for choice—but, at least for now, such talk is cheap.

Neil E. Weisfeld

NJM

“THERE IS
NOTHING MORE
EXHILARATING THAN TO BE
SHOT AT WITHOUT
RESULT.”



—WINSTON CHURCHILL

Princeton Insurance Company policyholders are winning the battle against frivolous professional liability claims: 95% of company-managed cases are resolved in our insureds' favor. A successful defense means an unscathed professional reputation *and* preservation of financial security.

In today's legal climate, even the best doctors must dodge a bullet now and then. To marshal the heavy artillery on *your* side, consult one of the independent agents who represent Princeton or call us at 1-800-433-0157.



Princeton Insurance Company

Professional Liability

Office Package Policy

Workers Compensation

Rated A- (Excellent) by A.M. Best Company 746 Alexander Road • Princeton, New Jersey 08540

REVIEW BOARD

Sofia Anthony, MD
 Paul W. Armstrong, Esq
 Richard M. Ball, MD
 Stanley S. Bergen, Jr, MD
 Harry M. Carnes, MD
 Gary S. Carter
 Elizabeth G. Christopherson
 Ellen M. Cosgrove, MD
 The Honorable Len Fishman
 Joseph E. Gonzalez, Jr
 Paul J. Hirsch, MD
 Ismail Kazem, MD
 Louis L. Keeler, MD
 Carol J. Kientz, RN
 James R. Knickman, PhD
 Paul R. Langevin, Jr
 George R. Laufenberg
 Martin S. Levine, DO
 Henry R. Liss, MD
 Gregg Lubinsky, RPh
 Ruth B. Mandel
 Michael R. McGarvey, MD
 Julane Miller
 Charles M. Moss, MD
 Patricia Murphy, PhD, RN
 Tom O'Neill
 Fred M. Palace, MD
 Mary Todd, DO
 William H. Tremayne
 F. Kevin Tylus
 The Honorable Charlotte Vandervalk
 Joan Verplanck
 Paul E. Wallner, DO

COUNCIL ON COMMUNICATIONS

Charles M. Mass, MD, Chair	Joseph W. Kozielski, MD
Harry M. Carnes, MD,	Clement H. Kreider, Jr, MD
Vice-Chair	Alan J. Lippman, MD
Henry R. Liss, MD, Vice-Chair	Robert M. MacMillan, MD
Richard M. Ball, MD	George J. Mellendick, MD
John P. Capelli, MD	Danald W. Orth, MD
Paul J. Carnial, MD	Robert M. Pallay, MD
Andrew B. Covit, MD	Sindy M. Paul, MD
Anthony Del Gaiza, MD	Arthur W. Perry, MD
Joseph A. Dilalla, MD	Niranjan V. Raa, MD
Michael J. Dayle, MD	Kelly M. Reid, MD
Leigh E. Ende, MD	Carl Restiva, Jr, MD
Steven C. Fiske, MD	Jahn C. Riggs, MD
Jack Goldberg, MD	R. Gregory Sachs, MD
Daniel P. Greenfield, MD, MPH	John D. Slade, MD
George H. Hansen, MD	Leon G. Smith, MD
M. Arif Hashmi, MD	Bessie M. Sullivan, MD
Christine E. Haycock, MD	Julie E.K. Timins, MD
Neil B. Harner, MD	Sandra S. Valdez, MD
Walter J. Kahn, MD	Paul E. Wallner, DO
Manroe S. Karetzky, MD	Richard A. Williams, MD
Ismail Kazem, MD	Angie Campa
Louis L. Keeler, MD	Eileen Martin Cohen
Scott P. Keil, MD	Anna Miranda

New Jersey MEDICINE

Health Care in the Garden State

EDITOR-IN-CHIEF
 Howard D. Slobodien, MD

EXECUTIVE EDITOR
 Geraldine R. Hutner, MA

ASSISTANT EDITOR
 Nancy M. Propsner, BA

ADVERTISING
 Cookson Media Services

PRODUCTION
 Trentypo, Inc.

PRESIDENT AND CHAIR
 Carl Restivo, Jr, MD

PRESIDENT-ELECT
 R. Gregory Sachs, MD

FIRST VICE-PRESIDENT
 Irving P. Ratner, MD

SECOND VICE-PRESIDENT
 Walter J. Kahn, MD

SECRETARY
 Bessie M. Sullivan, MD

TREASURER
 Eileen M. Moynihan, MD

IMMEDIATE PAST-PRESIDENT
 Anthony P. Caggiano, Jr, MD

BOARD OF TRUSTEES
 S. Manzoor Abidi, MD
 Stevan Adler, MD
 Angelo S. Agro, MD
 Churchill L. Blakey, MD
 Donald J. Cinotti, MD
 Rajendra Prasad Gupta, MD
 David A. Ingis, MD
 Philip J. Jasper, MD
 Elliot M. Kraus, MD
 Giovanni Lima, MD
 Mark T. Olesnick, MD
 Robert S. Rigolosi, MD
 Michael J. Spedick, MD
 John W. Spurlock, MD
 J. Jerome Cohen, MD, OMSS
 Andrew Kunish, MD, Speaker of the House
 Susan Kahn, MSNJ Alliance
 John Y. Lee, Medical Student
 Daniel M. Greenwald, MD, Medical Specialty Societies

New Jersey MEDICINE (ISSN-088-5842-X) is published monthly (since 1904) under the direction of the Council on Communications by the Medical Society of New Jersey (MSNJ), Two Princess Road, Lawrenceville NJ 08648. Printed in Lancaster, PA. by Lancaster Press. Printed in USA. Whole number of issues 1124. Member's subscription (\$10) is included in MSNJ dues. Rates for nonmembers are \$50; outside of USA, add \$20. Single copy is \$7.50. Periodicals postage paid at Trenton, NJ, and Lancaster, PA. Copyright 1998 by MSNJ. February 1998. Internet address: <http://www.msnj.org>. E-mail address: info@MSNJ.org, 609/896-1766. FAX 609/896-1368. Postmaster: Send address changes to *New Jersey MEDICINE*, Two Princess Road, Lawrenceville NJ 08648. The appearance of advertising in *New Jersey MEDICINE* is not a MSNJ guarantee or endorsement of the product or service, by the advertiser. When MSNJ has endorsed a product or program, that will be expressly noted.

Medical Society of New Jersey
MSNJ

When professional health law counsel is called for,
call the firm the experts are calling.



For years health care providers and businesses have been calling Theodosia A. Tamborlane P.C. when they needed accurate information, insightful commentary and practical advice. That's because Theodosia A. Tamborlane P.C. successfully navigates through the maze of government activity at both state and federal levels every day.

Today physicians, hospitals, nursing homes, assisted living, ambulatory care

facilities, home health care agencies and other providers turn to this firm for legal services including managed care contracting and corporate compliance plans. It's little wonder why leading health law publications and the nation's most prestigious legal, medical and business associations keep calling Theodosia A. Tamborlane P.C. to keep their members up to date. When you need professional legal counsel select the firm that knows the issues ...

Theodosia A. Tamborlane, P.C.



THEODOSIA A. TAMBORLANE, P.C.

COUNSELORS AT LAW

1044 ROUTE 22 WEST, MOUNTAINSIDE, NEW JERSEY 07092

908-789-7977

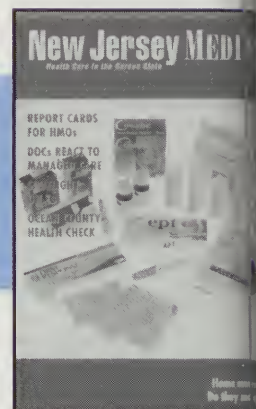
Member, American Medical Association Doctors Advisory Network

Charter Member, American Association of Physician-Hospital Organizations-Integrated Healthcare Delivery Systems

CONTENTS

- 27** HEALTH CARE FEATURE
Home medical tests increase in use and popularity
By Sheila Smith Noonan
- 31** CLINICAL REPORT
Work of a noninvasive vascular laboratory
By Clifford M. Sales, MD, RVT; Joanne N. Gerard, RVT
- 33** CURRENT TRENDS
For physicians frustrated with managed care
By Neil E. Weisfeld, JD, MSHyg
- 37** SPECIAL REPORT
Report cards hold HMOs accountable
By Len Fishman
- 41** PUBLIC HEALTH ADVANCES
The environmental health of Ocean County
By Elin A. Gursky, ScD
- 45** PUBLIC HEALTH ADVANCES
Helping victims of rape: A program called SANE
By Diane Haring Cornell
- 47** FINANCIAL MATTERS
Physician practice management companies may offer relief
By Patricia A. Costante
- 53** COMMENTARY
Celebrating 25 years of information services
By Duressa Pujat, MLS; Nancey Ryder-Cunningham
- 57** PRACTICE MANAGEMENT
Steering the course for medical group management
By Jane F. Rider

- NEWSWATCH 1
- MAIL STOP 8
- NEWSMAKERS 14
- ONLINE MSNJ 18
- EDITOR'S DESK 21
- MEMBERSHIP MATTERS 23
- IN THE SPOTLIGHT 25
- LEGAL FEATURE 51
- POINT COUNTERPOINT 59
- COMPUTERS IN MEDICINE 63
- CALENDAR 66
- F.Y.I. 75



Home medical tests are increasing in use and popularity. Are the tests ensuring up to physicians' patient demands? The story begins on page 27. Cover: © Conrad Glas

We know that practicing medicine is your primary concern.

The professionals at Healthcare Management Partners will take away the time-consuming administration and pressures of billing, collections, follow-up, office management, and system maintenance, so you can concentrate on doing what you do best - practicing medicine.

Contact Rosalie Fox or Robert Rahl at 609-734-0443 to find out more.

**Practice Assessments • Billing & Collection •
MIS Systems • Group Practice Formation •
Practice Management • Income Distribution**

**Endorsed Computerized Billing,
Accounts Receivable and
Information Management Company of the
Medical Society of New Jersey**



HEALTHCARE MANAGEMENT PARTNERS

PARTNERS IN PROFIT

200 Canal Pointe Boulevard • Princeton, NJ 08540-5998
609-734-0443 • FAX 609-243-9799

A Division of Health Information Consulting Services, Inc.



New Jersey MEDICINE

HIV resources

As a followup to my article, "The importance of screening pregnant patients for HIV," (*New Jersey MEDICINE*, December 1997) I am offering a suggested reading list. These references will help physicians and health care professionals continue to stress the importance of screening pregnant women for HIV.

1. DHSS: HIV/AIDS care summary, June 1996.
2. CDC Control and Prevention: HIV/AIDS surveillance report. 7:2, 1996.
3. U.S. Public Health Service: Recommendations for HIV counseling and testing for pregnant women, 1995.
4. Lindsay M: Protocol for routine voluntary antepartum human immunodeficiency virus antibody screening. *Am J Obstet Gynecol* 168:476, 1994.
5. U.S. Public Health Service: Recommendations on the use of zidovudine to reduce perinatal transmission of human immunodeficiency virus. *MMWR* 43:1, 1994.
6. AMNJ: Identification and management of asymptomatic HIV-infected persons in New Jersey. November 1996.

7. Barbacci M, Repke JT, Chaisson RE: Routine prenatal screening for HIV infection. *Lancet* 70:337, 1991.

Joseph Apuzzio, MD
UMDNJ-New Jersey
Medical School

Making sense of the law

Your editorial "Law is a ass—a idiot" is certainly apropos, and in that regard I highly recommend a book written by Daniel Lazare, *The Frozen Republic*, with advice about our constitution. We are riveted to this document, which also may account for the mindset we have about law. When a law is passed, we cleave to it, whether or not it makes sense. We criminalize a teacher for "raping" a 14-year-old boy when at the very

least she made a family with him and they seem to love each other; we create laws about sexual harrassment, which lets a Paula Jones, who shows no evidence of damage whatsoever, interfere with the leadership of this government for an alleged encounter that occurred years ago. Our coffers are emptied by the lack of limits on awards for "pain and suffering."

When Nixon went down, Anthony Lewis wrote that he thanked heaven we were a nation of laws, not men. But a nation must write sensible laws, else we all become mindlessly criminalized.

When the state of New Jersey among others decided to make the HIV-AIDS population invisible to authorities it circumvented law about sexually transmitted diseases stat-

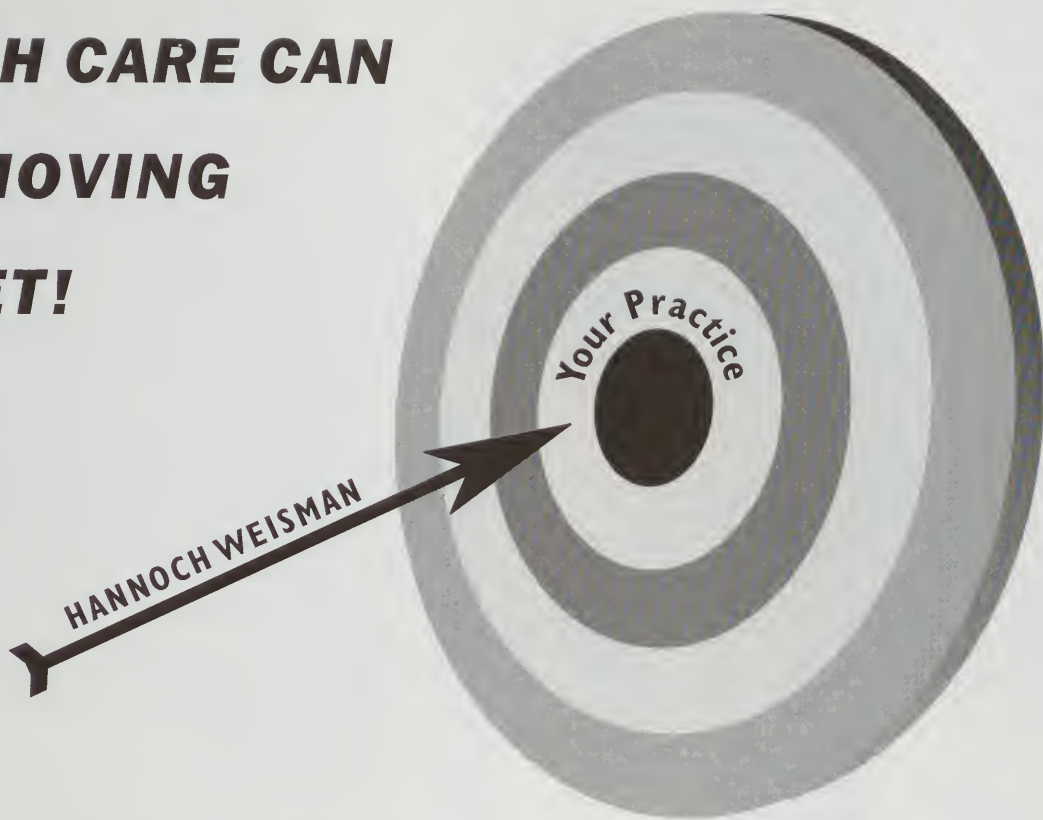
continued on page 12

Requirements for letters

To submit a letter, FAX (609/896-1368), e-mail (info@MSNJ.org), or mail your letter to *New Jersey MEDICINE*, Two Princess Road, Lawrenceville NJ 08648. Letters should be typed and double-spaced and should be no longer than 400 words with up to 4 references, if necessary. Include your full name, affiliation, address, and telephone number.

Letters are published at the discretion of the editor-in-chief and are subject to editing and abridgment. Letters may be published on MSNJ's web site, <http://www.msnj.org>. Financial associations or other possible conflicts of interest must be disclosed. Letters represent the opinions of the authors.

HEALTH CARE CAN BE A MOVING TARGET!



WHEN YOU CAN'T AFFORD TO MISS . . .

**HANNOCH WEISMAN HAS A RECORD OF HITTING
THE MARK WHEN ADVISING PHYSICIANS ON:**

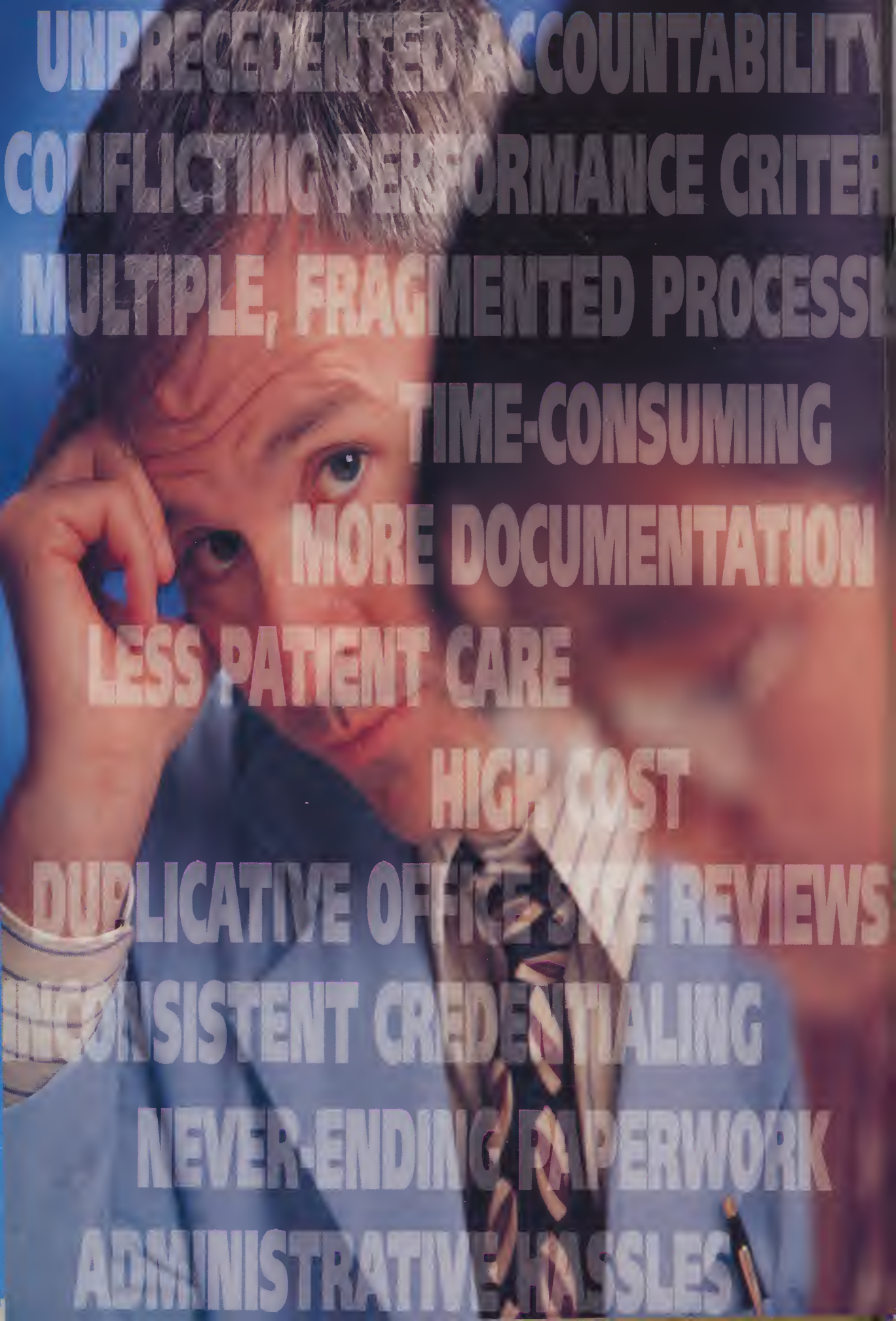
- ✓ Practice formation, management and operations
- ✓ Review and negotiation of managed care contracts
- ✓ Corporate transactions including mergers and acquisitions and joint ventures
- ✓ Licensing, peer review and disciplinary matters
- ✓ Professional liability and risk management
- ✓ Governmental and payor inquiries and investigations
- ✓ Medical staff relations and credentialing
- ✓ Employee relations and benefits

For assistance or information contact:

Lisa D. Taylor, Esq.

James J. Shrager, Esq.

Hannoch Weisman, A Professional Corporation
4 Becker Farm Road, Roseland, NJ 07068
973-535-5300



UNPRECEDENTED ACCOUNTABILITY
CONFLICTING PERFORMANCE CRITERIA
MULTIPLE, FRAGMENTED PROCESSES
TIME-CONSUMING
MORE DOCUMENTATION
LESS PATIENT CARE
HIGH COST
DUPLICATIVE OFFICE-SITE REVIEWS
INCONSISTENT CREDENTIALING
NEVER-ENDING PAPERWORK
ADMINISTRATIVE HASSLES

Our solution has arrived.

One Time

One Source

One Standard



American
Medical
Accreditation
Program

With the new American Medical Accreditation Program (AMAP), physicians complete an application **ONE TIME**, have their credentials primary-source verified **ONE TIME**, and have an on-site office review **ONE TIME**.

AMAP then provides an Accreditation report and certificate to each physician who meets the AMAP national standard.

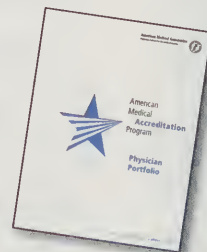
AMAP will provide a complete portfolio of verified credentials, office site review and other frequently requested information to each health plan and hospital that uses AMAP and with whom the physician is affiliated.

The American Medical Accreditation Program is a voluntary, comprehensive accreditation program that measures and evaluates individual physicians against national standards, criteria and peer performance in five areas: Credentials, Personal Qualifications, Environment of Care, Clinical Performance, and Patient Care Results.

Meeting and maintaining AMAP's high standard earns a physician AMAP Accreditation – a new national benchmark of physician quality.

AMAP, your one source for the new national standard of physician quality information, has arrived.

To learn more about the many benefits AMAP has to offer *your* organization, call the AMAP Resource Center at 1-888-881-AMAP (2627) or visit the AMAP Web site at <http://www.ama-assn.org>.



The standard in quality physician care.

American Medical Association
Physicians dedicated to the health of America



continued from page 8

ing that HIV-AIDS wasn't treatable. When I brought this matter to the attention of authorities, HIV-AIDS was made more visible on the basis of the fact that it was treatable, although not curable.

Another case in point involves persons punished for distributing needles to addicts. There comes a time when we have to make reasonable decisions about reasonable issues. In matters of public health, certainly the balance between individuals and society must be weighed before law is passed, and/or obeyed.

Law and mandated sentences do to judges what HMOs do to doctors: they take the decision making away from the professionals equipped by education and experience to make the decisions. We have to work toward becoming a reasonable society.

Charles Harris, MD

Temporal bone imaging

I was a big fan of the previous editions of *Imaging of the Temporal Bone* (Swartz and Harnsberger), and this third edition did not disappoint me. The book remains the standard in the field.

This third edition of the classic text on temporal bone

imaging represents a first-rate overhaul of the subject to encompass the most advanced practices in the field. As head and neck radiology has progressed to place a greater emphasis on MRI, so has *Imaging of the Temporal Bone*. The authors strive to include the latest MR techniques such as fast spin echo and 3-D imaging. Swartz and Harnberger once again approach temporal bone imaging in such an orderly fashion as to make the evaluation of this most complex bone in the body a more readily accessible subject.

The introduction consists of a superb guide to the more common symptoms of tempo-

ral bone disease. Each symptom is evaluated by use of an imaging algorithm outlining the indications for CT and MRI scanning. The remainder of the text systematically analyzes the anatomy and pathology of each segment of the temporal bone. Hence, the first chapter begins with the external auditory canal and progresses to the internal auditory canal. Specific disease entities are also discussed, including trauma and congenital anomalies.

Complementing the highly crafted written text are equally superior quality images from state-of-the-art scanners. Line illustrations are used to review the anatomy.

Neil B. Horner, MD



Networking for International Medical Graduates

All international medical graduates (IMGs) are welcome to attend MSNJ's newly formed **IMG Section** meeting on **February 18, 1998**, at MSNJ offices, at 5 P.M.

The IMG Section will act as a communications channel to MSNJ's House of Delegates, dealing with issues relevant to IMGs.

Please register for the meeting by calling Barbara Mihalik at MSNJ at 609/896-1766, extension 263.

LET'S TALK!

NEED A BUSINESS LOAN?
CALL US FOR...

EXPERT HELP
FABULOUS SERVICE
COMPETITIVE RATES
FAST APPROVALS AND CLOSINGS

up to approx. \$1,500,000 under the U.S. Small Business Administration Guaranteed Loan Program.

Approvals in 24 hours, or less.

Preferred (PLP) lender in New Jersey, New York and Pennsylvania.



Call 1-800-SBA-2005
ask for the "SBA Specialist"

PRESTIGE STATE BANK

Equal Housing Lender Equal Opportunity Lender

Member FDIC

MAC

STARS

The Medical Manager[®]

Practice Management Software

A fully integrated practice management solution

Over 16 years' experience in providing
healthcare automation solutions

Provides an open system architecture
and flexibility for specialized needs

Designed for small group practices to large
Integrated Delivery Systems

Overwhelming national presence

Learn more about how Medical Manager Corporation and
The Medical Manager system can meet your needs. Contact us
at 800.677.7784, 201.808.0088, or www.medicalmanager.com.

**Medical
Manager**
Corporation

RTI, Inc. and Medix

Empowering the Industry Through Partnership



OF NORTH JERSEY & NEW YORK

is now

ImageFIRST[™]

MEDICAL WEAR

Your
R_x
for linen rental.

*Programs include weekly delivery and cleaning of
lab coats, scrubs, fluid resistant wear, towels and more.*

1-800-368-3676



Thomas K. Evans, MD

Leader at wound center

Thomas K. Evans, MD, has been appointed medical director of the Mercer Medical Center Wound Care Center. A member of MSNJ and of Mercer County Medical Society, Evans is a board certified general surgeon and fellowship trained peripheral vascular surgeon. Evans received his medical degree from Temple University School of Medicine. As a member of the Mercer County Medical Society, Evans serves as a delegate to the MSNJ House of Delegates.



Dr. Wallner, Steve Adubato, and Dr. Klein

PBS leads the way

MSNJ members **Patria Klein, MD**, a neurologist at Holy Name Hospital and Pascack Valley Hospital, and **Paul E. Wallner, DO**, a radiation oncologist from Cooper Hospital/University Medical Center, appeared on the television show, *Caucus: New Jersey*. The show features interviews with New Jersey's most compelling and influential citizens, hosted by Steve Adubato.

Hospital services get kudos from HRET

Three New Jersey hospitals were recognized for their outstanding efforts to serve their communities. Honored with the Health Research and Educational Trust of New Jersey annual Community Outreach Awards were **Clara Maass Medical Center** (best program for mothers and children), **Morristown Memorial Hospital** (best program for the elderly), and **St. Mary's Hospital** (best program for populations with special needs).

Clara Maass Medical Center's First Step program visits new mothers in underprivileged urban areas offering prenatal, postpartum, and neonatal care and education. Mor-

ristown Memorial Hospital's Case Management for the Frail Elderly initiative offers a variety of services to the elderly that allows them to remain at



home rather than in institutions. St. Mary's Hospital's Caritas-Care Connection Outreach Project reaches out to the immigrant populations providing health screenings and health and safety education programs.

Alliance gears up for 1998

For over 75 years, the MSNJ Alliance has been working hand-in-hand with MSNJ to improve the health of the residents of New Jersey. The Alliance's 1998 year is off to a busy start with three projects: the Doctors' Day Gala, the Teen Health Seminar, and the Washington, DC, Legislative Bus Trip.

The MSNJ Alliance hosts one of the biggest celebrations to honor the physicians of the Garden State: the **Doctors' Day**

Gala, scheduled for March 28, 1998. For ticket information to this special function, call 609/896-1766, ext. 254.

MSNJ and the MSNJ Alliance annual Washington, DC Legislative Bus Trip is scheduled for March 9-10, 1998. Don't miss the opportunity to meet with members of Congress.



Susan Kahr, MSNJ Alliance president

continued on page 16

Critical Treatment for the Future of Your Practice...



Before It's Too Late

Wilentz, Goldman & Spitzer's Health Care Law Practice Group serves health care professionals regarding: group practice formation and operations; management service organizations (MSOs); physician practice management companies (PPMCs); managed care contracting; physician-hospital organizations (PHOs); independent

physician associations (IPAs); restrictive covenants; and regulatory, employment, tax and litigation matters. **Think of us as preventive medicine for your practice.** For information please call our Health Care Law Practice Group Co-Chairs: Michael F. Schaff at (732) 855-6047 or Francis V. Bonello at (732) 389-5636.

**WILENTZ
GOLDMAN
& SPITZER**
ATTORNEYS AT LAW

"Helping The Health Care Professional"

Woodbridge, NJ • Eatontown, NJ • New York, NY

<http://www.newjerseylaw.com>

continued from page 14

People in the news



William H. Hardesty, MD

William H. Hardesty, MD, a member of MSNJ, has been elected a Governor-at-Large to the Board of Governors, American College of Surgeons.

Lynn Jensen, PhD, has become the full-time chief operating officer and interim executive vice-president of the AMA.

The Health Sciences Library Association of New Jersey presented **Mary R. Scanlon, MLS**, with the Librarian of the Year Award and **John W. Sensakovic, MD**, with the New Jersey Healthcare Administrator of the Year Award.

The Princeton-based New Jersey Hospital Association (NJHA) appointed **Theresa**



Theresa Edelstein

Edelstein director of Continuing Care Services and **Sally Roslow** director of Development. Edelstein comes to NJHA with varied experience in health care planning and adminis-

tration, including positions at Kessler Rehabilitation Corporation, The Jewish Home & Hospital, and Saint Barnabas Health Care System. Roslow gained fundraising experience with New Jersey Network, Temple University School of Dentistry, and WHYY television and radio networks.



Sally Roslow

National nursing recognition

Robert Wood Johnson University Hospital joins six other hospitals nationwide that have reached nursing excellence. The hospital has been designated the Magnet Award by the American Nurses Association (ANA). The program provides national recognition to Robert Wood Johnson University Hospital for its excellence in nursing services; it also recognizes the 1,000 plus nurses at Robert Wood Johnson University Hospital as among the best in the nation. "The nursing service at Robert Wood Johnson University Hospital has achieved the highest award and each nurse should be recognized for his or her individual contribution to excellence," said Jennifer Matthews, PhD, RN, CS, director, Accreditation and Magnet Recognition Programs, ANA.



Clifton Lacy, MD, Kathi Kendall Seng, MD, Jennifer Matthews, PhD, RN, and Harvey Holzberg.

Memory fitness

Just as exercising your body makes your muscles stronger, exercising your brain strengthens your mental abilities. Pick up the easy-to-read workbook, **Mind Aerobics: The Fundamentals of Memory Fitness**. With this self-paced, interactive format, learn about how your memory works and short- and long-term memory. Participate in exercises, quizzes, and other methods to enhance and sharpen your memory. The author, Phil Bruschi, is the president of the New Jersey-based consulting company, MIND AEROBICS.

MIND AEROBICS:

The Fundamentals of Memory Fitness

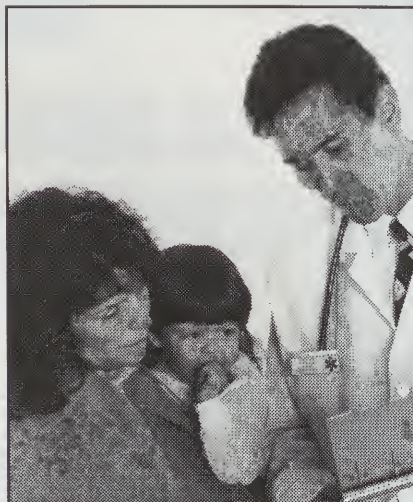


by Phil Bruschi

NJM

what if[®]

you could choose a health plan that meets all your needs and fits your budget?



You can with the Medical Society of New Jersey's endorsed health carrier of choice. . .



**BlueCross BlueShield
of New Jersey**

If you're an individual or have a family to support, choose from:

- *HMO Blue*
- *HMO Blue* Prime
- Traditional Plans A, B, C, D, and E
- Basic BlueSM (Plan A)
- And our new **M\$A BlueSM** plan with its tax advantages!

If you run a small business, choose from:

- *HMO Blue*
- *HMO Blue* Prime
- Blue SelectSM
- Blue Choice[®]
- Blue Choice[®] Prime
- Traditional Plans A, B, C, D, and E
- And our new **M\$A BlueSM** plan with tax advantages for employers and employees!

OR customize one plan for your company's specific business needs by combining as many as three of these plans. All offer attractive benefits. . . **All offer a 1-year rate guarantee upon enrollment!**



**BlueCross BlueShield
of New Jersey**



**INDIVIDUAL &
SMALL EMPLOYER
DIVISION**

Ask us for a free
copy of the SEH
Buyer's Guide.

Call your Blue Cross and Blue Shield of New Jersey

Medical Society of New Jersey
MSNJ

Sales Representative

JENNIFER ALTOBELLI

1-908-493-8808

® and SM Registered Marks and Service Marks of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans. Blue Cross and Blue Shield of New Jersey and HMO Blue are Independent Licensees of the Blue Cross and Blue Shield Association. HMO Blue is a subsidiary of Blue Cross and Blue Shield of New Jersey.

The top 25 medical sites

Edited by John W. Hoben, the 1998

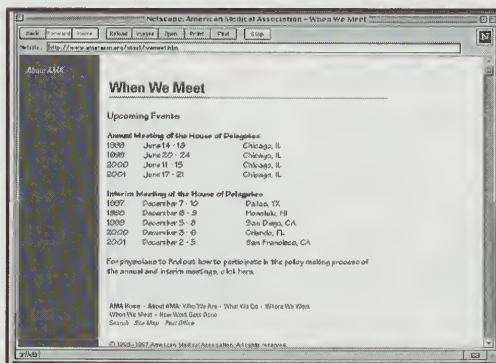
Guide to Health Care Resources on the Internet is worth having on hand. At a glance you can pick out the best medical sites for you. Hoben presents



his pick of the top 25 web sites in eight categories. You'll find an overview of each web site that includes a screen snapshot of the site and an easy-to-review table that rates areas like target audience, unique content, and content development. The softcover manual is published by Faulkner & Gray (www.FaulknerGray.com/healthcare).

Facelift for the AMA

Next time you log onto the AMA's web site (www.ama-assn.org), expect to get around faster and easier, plus a cleaner, crisper look. To accommodate heavy traffic, the AMA added new features and revamped



existing sections. Expanded consumer sections; a new section, "For the Media"; and additional members-only information are a few of the changes to the site.

Front page news

If it's the hottest topic in the health care field, you'll find it covered in the Newswatch column (under "What's New") on MSNJ's web site (www.msnj.org). Written by MSNJ deputy executive director, Neil E. Weisfeld gets to the heart of the issues with concise—yet indepth—accounts of the most up-to-date news in health care.



The recent edition of Newswatch gets behind-the-scenes with the AMA Sunbeam controversy and New Jersey physicians' role, and the column covers what's unfolded in Trenton since Governor Whitman's re-election.

Bookmarks

www.state.nj.us/health

Access the Department of Health and Senior Services' HMO report card.

www.nationalgeographic.com

Take a quick look at this top-notch site of National Geographic.

www.medecinteractive.com

From the publishers of Medical Economics, MedEd Interactive is a physicians-only site that's great for medical research.

www.ampainsoc.org/

Tap this site, by the American Pain Society, for extensive information about pain and pain management.



100% NO LOAD

T. Rowe Price Summit Funds

THE ROAD TO HIGHER YIELDS IS PAVED WITH LOWER EXPENSES



T. Rowe Price Summit Funds

Give your money more earning power with Summit Funds: six no-load, tax-exempt, and taxable bond and money market funds that offer investors an opportunity to earn more.

High yields and lower expenses

A \$25,000 minimum initial investment per fund is the reason you pay less in expenses. Summit Funds' higher account balances help us manage more cost-effectively and keep fees low. In fact, Summit Funds' fees are substantially lower than the average cost of comparable fixed income mutual funds.* All things being equal, lower expenses can provide higher yields and help you *keep more of what your money earns*. Of course, yield and share price will fluctuate with interest rate changes. Past performance cannot guarantee future results. **Free checkwriting** No sales charges of any kind.**

**Call 24 hours for a free
report and prospectus
1-800-541-4705**

SUMMIT INCOME FUNDS

SUMMIT CASH RESERVES††

Current 7-day yield as of 1/5/98:

5.41%

Objective: Preserve capital and provide liquidity

Invests in: High-quality money market securities

SUMMIT LIMITED-TERM BOND

Current 30-day yield as of 12/21/97:

6.05%

AVERAGE ANNUAL RETURNS:†

1-year: **7.16%**

Since inception (10/29/93): **4.72%**

Objective: High level of current income

Invests in: Investment-grade corporate bonds

SUMMIT GNMA

Current 30-day yield as of 12/21/97:

6.49%

AVERAGE ANNUAL RETURNS:†

1-year: **9.77%**

Since inception (10/29/93): **6.96%**

Objective: Highest possible current income

Invests in: High-quality, government mortgage-backed securities

SUMMIT MUNICIPAL FUNDS

All exempt from federal income taxes***

SUMMIT MUNICIPAL MONEY MARKET††

Current 7-day yield as of 1/5/98:

3.51%

Objective: Capital preservation and liquidity

Invests in: High-quality municipal money market securities

SUMMIT MUNICIPAL INTERMEDIATE

Tax-equivalent yield 36% tax rate:

6.59%

Current 30-day yield as of 12/21/97:

4.22%

AVERAGE ANNUAL RETURNS:†

1-year: **8.42%**

Since inception (10/29/93): **6.30%**

Objective: High income

Invests in: Investment-grade municipals

SUMMIT MUNICIPAL INCOME

Tax-equivalent yield 36% tax rate:

7.47%

Current 30-day yield as of 12/21/97:

4.78%

AVERAGE ANNUAL RETURNS:†

1-year: **11.64%**

Since inception (10/29/93): **7.11%**

Objective: Highest possible income

Invests in: Long-term, investment-grade municipals

Invest With Confidence®
T. Rowe Price



Average annual returns are for the periods ended 12/31/97 and include changes in principal value, reinvested dividends, and capital gain distributions. Investment return and principal value may vary, and shares may be worth more or less at redemption than at original purchase. Figures are for Taxable Money Market, Short-Term Corporate, GNMA, Municipal Money Market, Municipal Intermediate, and Municipal General Bond Fund categories, respectively, as of 3/1/97. Source: Lipper Analytical Services, Inc. **\$500 minimum. ***Some income may be subject to state and local taxes and the federal alternative minimum tax. These funds are neither insured nor guaranteed by the U.S. government, and there is no assurance that they will be able to maintain a stable \$1.00 net asset value. Read the prospectus carefully before investing. T. Rowe Price Investment Services, Inc., Distributor.

SUM040635

Whether it's an alcohol or drug problem, count on Sunrise House for expert help.

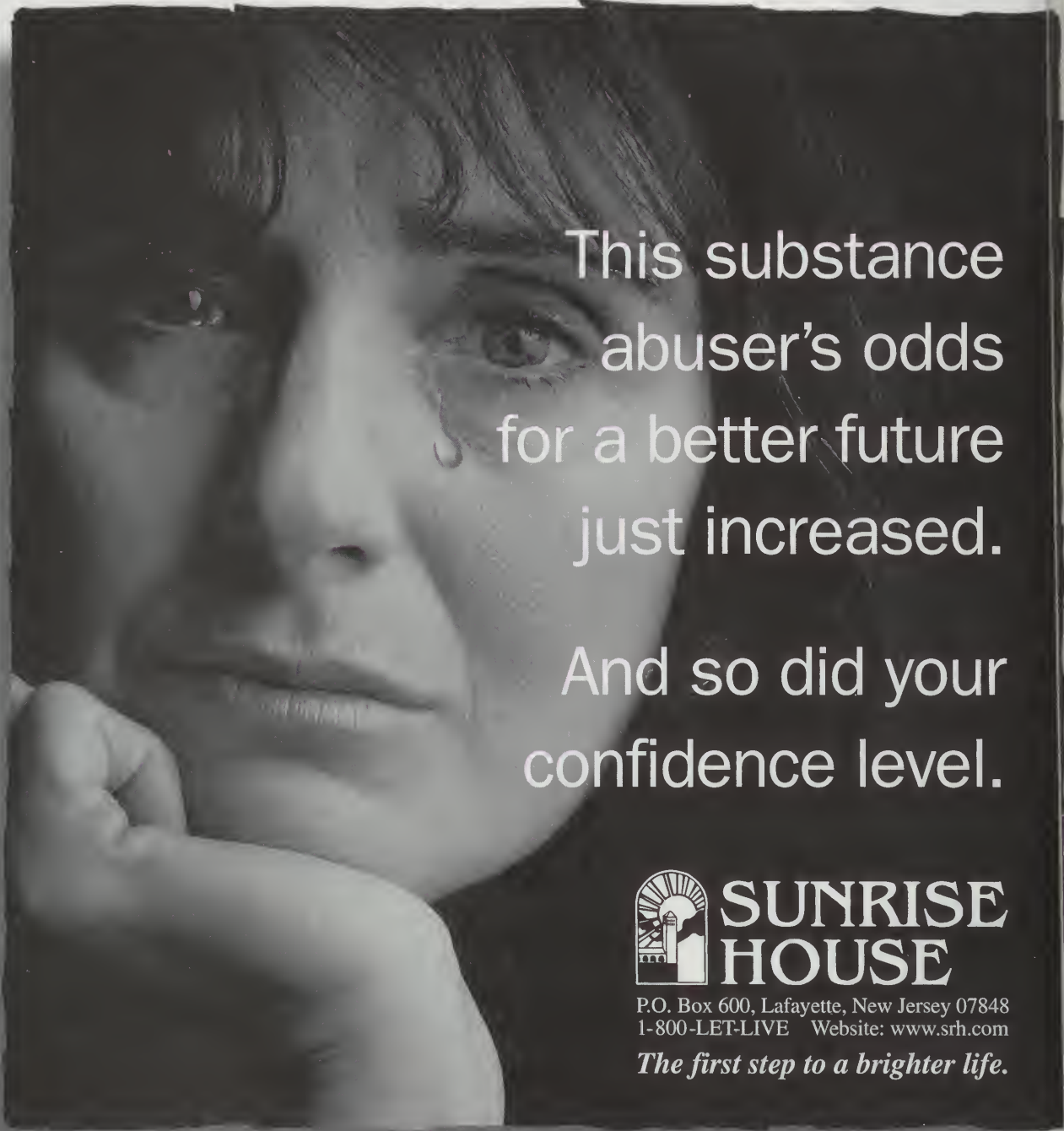
For 14 years, hundreds of tri-state area doctors have trusted us to offer their patients the most effective, caring treatment and a chance for a better life.

Set in the scenic hills of northwest New Jersey, we're a licensed, nonprofit specialty hospital with a nationally known commitment to quality—including Accreditation with Commendation by the JCAHO.

Our comprehensive programs include inpatient and outpatient services, after-care and family support.

And our experienced staff of doctors and specialists works closely with referring physicians to ensure continuity of care at every stage of treatment.

Sunrise House. High-quality, affordable treatment you can trust. For information, call us at 1-800-LET-LIVE or (973) 383-6300.



This substance
abuser's odds
for a better future
just increased.

And so did your
confidence level.



**SUNRISE
HOUSE**

P.O. Box 600, Lafayette, New Jersey 07848
1-800-LET-LIVE Website: www.srh.com

The first step to a brighter life.

Sunrise House is a preferred provider of most major insurance companies and HMOs.
We will process insurance benefits verification and precertification.

How to succeed in business: Part II

Some people disagree with the concept of altruism: disinterested benevolence. They feel that everything is done with self-interest. Nevertheless, service for the sake of others has been an integral part of the medical profession, although changes in recent years make one wonder how much still exists.

In October 1995, I wrote about battles raging over the patent rights of drug manufacturers and of the patent requested by an Arizona ophthalmologist for a sutureless cataract operation. Today we have the spectacle of similar commercialism in the laboratory field.

The New York Times headlined on December 25, 1997: "Health Groups Fight Patent for Medical Test." Biomedical Patent Management Corporation (BPMC) was granted a patent in 1989 for an observation: that the level of human chorionic gonadotropin (HCG) was related to the development of Down's syndrome. Although a subsequent investigation showed that HCG alone was an unreliable marker for the syndrome, the patent still is valid. And because HCG is one of the several tests needed in prenatal screening to predict Down's syndrome with any reliability, BPMC expects royalties every time HCG is tested, in millions of pregnant women each year. Kaiser Permanente has sued to invalidate the patent and has been joined by a significant portion of the scientific

community, including the American Medical Association, which will afford money, expert testimony, and other services.

An editorial in the October 1997 *Journal of the Royal Society of Medicine* (JRSM), reviewed Richard Titmuss' *The Gift Relationship*, published in 1970 and reissued this past year with updating and commentary. This book, as

noted by JRSM, keeps alive "the cradle of altruism in fairly dark days." Although Titmuss, who died in 1973, focused primarily on blood donations, his comments about the replacement of altruism by financial concerns and self-interest have increasing meaning today.

Julian Le Grand, the Richard Titmuss Professor of Health Policy at the London School of Economics and Political Science, has added a meaningful "Afterword" to the latest edition. He notes that Titmuss extended his views to "argue against the use of markets in broader areas of medicine and

health care, against their introduction into other areas of social policy and . . . they limited individual freedom, especially the freedom to give; and they corrupted, turning altruists into narrow self-seekers." Le Grand asks, "Will the introduction of the bad money of self-interest drive out the good coin of altruism? Will the ethics of professionalism be



Howard D. Slobodien, MD

We ask,
"Will the
introduction
of the bad
money of
self-interest
drive out
the good
coin of
altruism?"

If charity cost no money and benevolence caused no heartache, the world would be full of philanthropists.

Yiddish Proverbs, ed. Hanan J. Ayalti, 1949

He that gives his heart will not deny his money. Thomas Fuller, MD, *Gnomologia*, 1732

eroded and replaced by a greed mentality? Will the trust relationship between doctor and patient . . . be irretrievably damaged? And will taxpayers ever see themselves again as part of a collective enterprise helping the less fortunate, or will they simply be concerned with preserving only those services from which they directly benefit, while happily supporting moves to cut the rest?"

A recent survey of all 157 allopathic and osteopathic medical schools in the United States showed that 98 percent administered a code of ethics or an oath. Most medical schools used some version of the Hippocratic oath and all pledged commitment to patients. Unhappily, only 43 percent vowed to be accountable for their actions.

Let us review selected passages from various codes and oaths promulgated over many centuries:

- Amatus Lusitanus in Dr. Aaron Feingold's *Three Jewish Physicians of the Renaissance*: "I have not been desirous for the remuneration for medical services and have treated many without accepting any fee, but with none the less care."

- From John Fabre's *The Hippocratic Doctor, Ancient Lessons for the Modern World*: "Precepts (chapter IV)—Should you begin by discussing fees, you will suggest to the patient either that you will go away and leave him if no agreement be reached, or that you will neglect him and not prescribe any immediate treatment. So one must not be anxious about fixing a fee."

- From the International Code of Medical Ethics of the World Medical Association (1949): "A doctor must practice his profession uninfluenced by motives of profit. Receiving any money in connection with services rendered to a patient other than a proper professional fee, is unethical."

- Prayer of Maimonides (1793): "Do not allow thirst for profit, ambition for renown and admiration, to interfere with my profession, for these are the enemies of truth and of love for mankind."

A modern version of the Hippocratic oath says: "I will prescribe regimens for the good of my patients according to my ability and judgments but never violate the rules of Medicare, Medicaid, HMOs, preferred-provider organization (PPOs), and the like. . . . Should I and my colleagues, with only the most honorable of intentions, meet to set and maintain professional standards or eliminate excessive fees, may the Federal Trade Commission suitably punish us for our noble efforts. . . . If I keep this oath faithfully, may I survive this hostile medical environment long enough to discover an alternative career so that I may enjoy life respected by all people and in all times."

Albert Schweitzer and Mother Teresa must be spinning in their graves. It seems that charity now is being given to managed care organizations, to their subscribers, and to their stockholders, but not to patients. Isn't it disheartening that, of all the major democracies, only the United States, the richest nation on earth, denies available care because of lack of money or of insurance coverage. President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry released its "Consumer Bill of Rights and Responsibilities" at the start of the year. These rights include those related to information, choice of providers, emergency health services, decision making, consideration and respect, confidentiality, and fair resolution of differences. Unhappily, I saw nothing relating to the right of Americans to receive reasonable, non-emergency medical and health care.

REFINING EVALUATION AND MANAGEMENT CODES

*Eileen M. Moynihan, MD
Carl Restivo, Jr, MD*

Dr. Moynihan is MSNJ treasurer and Dr. Restivo is MSNJ president.

A few years ago, a cooperative project between the American Medical Association (AMA) and the Health Care Financing Administration (HCFA) was initiated to standardize the content and understanding of evaluation and management (E & M) services so that physicians and their office staff personnel could choose the appropriate common procedural terminology (CPT) codes to describe the level of effort performed. It also was undertaken to assist physicians and carriers in coming to agreement regarding the level of code billed in the audit process.

The CPT Editorial Panel began work on the project in the early 1990s. Initially, the history and medical decision-making components were completed and implemented in 1994. The physical examination portion, the most controversial piece, was recently released for implementation after review,

not only by the CPT Editorial Panel, but also by the Relative Value Update Commission (RVUC) of the AMA. Some adjustments were made by RVUC to be sure that work for the general multisystem examination was equivalent to the individual specialty examinations and that the individual specialty examinations were equivalent to each other.

Since the release of the E & M guidelines, many concerns have been raised by physicians and physician groups. These concerns included that a detailed or comprehensive examination appropriate to the patient's problem may not be credited because essential elements cannot be substituted. Conversely, performance of defined elements of the examination may be extraneous to the individual patient's problem. The physician no longer has the ability to tailor the examination to the patient's chief complaint and history. Some physicians feel that the documentation requirements are extensive and tantamount

to a "pay cut" as they are burdensome to execute. In the past, physicians had little chance of having records reviewed as reviews were initiated by physician complaint or statistical aberration. Now, there are pre-pay random audits. Three percent of physicians will have their records randomly reviewed. At the December 1997 Interim Meeting of the AMA, the House of Delegates requested HCFA to further revise these guidelines. Changes must be specifically petitioned before the AMA CPT Editorial Board. MSNJ was informed that the punitive portions of the regulations, i.e. \$10,000 fines to a maximum of \$250,000, were postponed by HCFA until July 1998. HCFA also promised to make efforts to educate physicians about the new E & M codes.

The E & M guidelines appear to precisely define what documentation is required to carrier reimbursement. Physicians have made it clear to HCFA that they feel further refinement is needed.

NJM

To increase cash flow, simply remove the tail.

Most New Jersey malpractice insurance policies require you to purchase a reporting endorsement — known as a tail — to protect against claims that may occur during retirement. B.C. Szerlip offers a unique policy from an A+ rated company that does not include an annual tail premium. In fact, if you maintain coverage with us until retirement, you'll *never* have to purchase a tail, and you'll still be protected.

That's just one example of the creative ways that B.C. Szerlip has discovered to help doctors with their long-range financial planning.

At B.C. Szerlip, we take a big-picture view of your practice, offering you comprehensive insurance and financial planning services. You can benefit from our nearly two decades of experience providing malpractice insurance for medical offices both large and small. In addition, our financial planners can offer strategic guidance for the overall health of your business affairs, so you can stay focused on the health of your patients.

We'd like to give you a taste of our full-service approach by sending you *The Managed Care Survival Kit for Physicians*. To receive your complimentary copy of this useful guide, please call us at 800-684-0876.

BCSZERLIP INSURANCE AGENCY INC.

99 WOOD AVENUE SOUTH, PO BOX 217
ISELIN, NJ 08830-0217
800-684-0876 • 732-205-9800
FAX: 732-205-9496
E-MAIL: bcszerlip@aol.com

*Professional Insurance Services
for Health Care Providers*

Gilbert W. Bates, P.A.

Legal services for Physicians and Their Practices

Practice Formation
Managed Care Contracts
Employment Agreements
Buy-In and Buy-Out Agreements
Practice Sales and Acquisitions
Practice Mergers

Flat Fee Arrangements Available

(609) 566-4541

You take care of your patients. We'll take care of the health of your practice. Our group of health care accounting specialists provides the medical community with the right type of analysis and counseling to be successful.

Since we're dedicated to increasing your profitability, never simply reporting it, we'll see

to it that your practice stays healthy for many years to come. To experience our unique approach, please call Ira S. Rosenbloom, Managing Director, at 973-882-1100.

PRACTICE
GOOD FINANCIAL
MEDICINE.



Mintz Rosenfeld & Company LLC

Profitability Consultants • Certified Public Accountants
60 Route 46 East, Fairfield, NJ 07004
Tel: 201-882-1100 Fax: 201-882-1560

OUR FOCUS IS YOUR SUCCESS.

Robin K. Levinson

INTERVIEW WITH LEE B. REICHMAN, MD, MPH

Since the 1970s, Lee B. Reichman, MD, MPH, has been waging war against tuberculosis (TB). In New Jersey, he is winning. As executive director of the UMDNJ-New Jersey Medical School National Tuberculosis Center, in Newark, Reichman oversees 60 employees with an annual budget of \$5 million in state and federal funds. The Center's innovative educational strategies and aggressive treatment efforts have resulted in cure rates as high as 97 percent. Reichman, a pulmonologist, works closely with the New Jersey Department of Health and Senior Services, and has served on national and international boards and committees dedicated to fighting TB and other lung diseases.

Q. What precipitated the most recent surge in TB rates?

A. TB rates had been going down since 1953 when the federal government was putting

a little bit of money into it. Around 1970, the then-Nixon Administration said it was unnecessary to give all this money directly to TB; why not give it to the states in the form of block grants? At the time, some people said, "You're making a terrible mistake because you're going to destroy the infrastructure that controlled TB." But they didn't listen. From 1971 to 1980, there was no direct money for TB. Health departments would have to pay themselves for programs that were not politically sexy, or they decimated their programs.

The TB rates leveled off in 1984 and rose 20 percent between 1985 and 1992. Some of us started pointing out that rise, but Congress acts very slowly, especially when it comes to conditions that primarily affect poor people and minority groups.

Q. What happened next?

A. In 1992—mostly out of fear of a multidrug-resistant TB spread among health care workers—Congress raised appropriations from \$10 million to \$150 million, which led to the funding of our Center. This has allowed us to educate

lay and professional people about TB and also to demonstrate that strategies can work to control TB in New Jersey. For instance, we have a 97 percent cure rate in Newark, which has large homeless, substance abuse, and AIDS populations, which constitute most of our patients.

Q. What's the best strategy to cure actively infected patients?

A. Our tactics are similar to what's used by the World Health Organization—directly observed therapy (DOT). We have a cadre of about 15 well-trained field workers, who are essentially educated lay people and directed by registered nurses. These field representatives are grouped into four case-management teams, each of which takes care of a panel of 30 to 40 patients within a particular zip code.

The field representatives know their patients like family, even patients who are homeless. They'll meet a patient in Penn Station, in a vacant lot, or on a street corner, give them their medicine, watch them take it, and record it in a chart. Our field representatives go to the most dangerous streets in

Newark. They are responsible not only for delivering and supervising every dose of medication, but helping solve patients' social problems, too. They're buddies to the patients.

Q. What is the current treatment for active pulmonary TB?

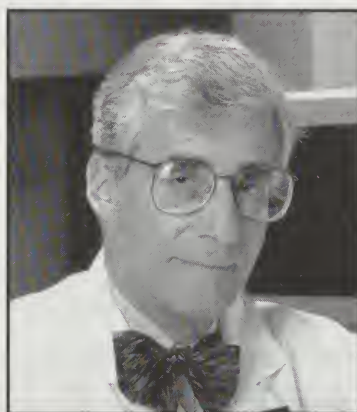
A. Patients are given a "cocktail" of four antibiotics for the first two months of treatment, usually followed by two antibiotics for the next four months. If a patient has resistance, they'd have to take more toxic drugs or undergo surgery. Because we have very little attrition and because we watch them take their medication, our resistance rate is extraordinarily low. If people take their medicine properly, they will not build up resistance.

Q. What is the thrust of your current research?

A. Our main project is our model center for TB control and prevention. We're also doing drug trials of rifapentine, a once-a-week treatment for TB. Rifapentine is given in the continuation phase, after the patient has completed a two-month course of initial daily treatment. We're trying to determine if the toxicity and response rates are any better than existing regimens. Once-a-week treatment makes supervised therapy more manageable. This looks like a fabulous drug. If you can treat

one of the oldest diseases of mankind with a once-a-week treatment, that's outstanding.

Another study we're doing is evaluating a particular computer software to track occupational exposure of TB among hospital employees and health care workers.



Lee B. Reichman, MD, MPH

Q. Should primary care physicians routinely screen patients for TB?

A. Everybody who enters a new health care delivery system should have a tuberculin test, even if they live in a low-incidence area. If you're going to measure a blood pressure, a tuberculin test is just as innocuous.

One-third of the world's population and 15 million Americans are infected with the TB bacillus. The largest component of TB in the United States—37 percent of cases—is foreign-born individuals, and New Jersey is a big port of

entry. It's not that they come in with active, hot TB, it's that they carry with them the TB rates from their country of origin. We don't want to be xenophobic, but these foreign-born individuals primarily live in Princeton, Tenafly, Short Hills, Trenton, and downtown Newark.

Anyone who tests positive for TB should be evaluated for prophylactic treatment. We take a chest x-ray, which tells if the patient has pulmonary TB—the only infectious kind. Then we determine, based on the patient's age and risk factors for TB, whether to give preventive treatment for six months. If you have a patient who's at high risk for developing active disease because it's a recent infection, or the patient is in contact with a recent case, or is immunosuppressed, and you give the patient isoniazid for six months and make sure it is taken, then you have done more for the TB control effort in this country than learning how to treat an exotic case of TB.

Q. How can health care professionals learn more about TB control and treatment?

A. Call the information line at 800-4TB-DOCS. We have a web site, www.umd-nj.edu/ntbc, which lists educational and training programs and upcoming conferences.

Home medical tests increase in use and popularity

Sheila Smith Noonan

After five months of trying to conceive, 29-year-old Heather Abrams sought help not from her doctor, but from a drugstore shelf. She bought an ovulation predictor test, and read and followed the instructions and very shortly after became pregnant.

"I had read that it could take a healthy woman up to a year to conceive. For \$18, I thought the ovulation predictor test was worth trying. If that had failed, then I would have seen my doctor," she said

Abrams is one of the growing number of Americans who use home medical tests or collection kits. According to some estimates, sales of these kits reached close to \$1 billion last year. Whether the motivation is privacy, convenience, economics, anxiety, autonomy, or simply following a doctor's instructions, many people are opting for home tests.

In the comfort and privacy of their homes, people can test for hidden fecal blood and check

their cholesterol or glucose levels. They can take their own blood pressure, or look into another person's ears with an otoscope. For about 20 years, women have used home pregnancy tests; more recently, the Food and Drug Administration (FDA) has approved home sample collection kits for both HIV testing and the presence of certain illegal drugs.

Jim Brody, MD, associate director of the Jersey Shore Medical Center's internal medicine residency program, noticed a rapid growth in home test use among his patients over the past two years. And while pleased that people are taking a more active role in their health care, he has some caveats regarding home tests. "What many patients don't realize is that none of these home tests is truly diagnostic," the internist says. "These tests are screening tools, and any result should be followed up by a more specific test that could lead to a diagnosis."

The most common home test Brody orders is for hidden fecal blood. The test's benefits are unquestioned; early on, many gastrointestinal diseases may produce blood in the stool.

However, as with any other test, directions must be followed carefully, as diet and even chemicals in toilet bowl water can affect results. Brody's patients receive specific counseling on how to use the test. Theoretically, he says, it should not matter whether patients receive test information from a package insert or from their doctor. "But we find that the information is imparted more precisely if it comes from the doctor or nurse," he says.

Robert M. Pickoff, MD, medical director at St. Peter's Medical Center in New Brunswick, says the most common home test he encounters is the blood pressure monitor. "There's an entire debate about its usefulness because the monitors have such a wide variety of quality," he says. "Generally, they are of limited value and tend to be overused."

"I see people coming to the emergency room in the middle of the night because of a high blood pressure reading, when it really is not the case," continues the internist/cardiologist. He adds that there are significant differences between the 24-hour blood pressure monitors doctors

prescribe, which are technically sophisticated, and the drugstore models most people buy. He asks patients to bring in their monitors to compare readings with office blood pressure measurements and to make sure the devices are being used properly.

Pickoff finds value in other home tests, including blood glucose monitors. "Patients in advanced stages of diabetes or knowledgeable, motivated patients can adjust their insulin based on blood glucose readings," he says. "The value of knowing blood glucose levels is infinite."

Perhaps the most controversial FDA home test approval has been for HIV collection kits. As the kits were being considered, proponents argued that enabling people to anonymously send blood samples to a laboratory and receive results by telephone would boost testing rates. Opponents claimed receiving word of HIV infection over the telephone—even by trained counselors—could have serious consequences. Less than two years after FDA approval, the debate over home HIV collection kits continues.

Katie Leone, director of Barnert Hospital's Treatment Assessment Program (TAP) Services, an early intervention HIV clinic, has mixed feelings about home collection. "If it gets people tested for HIV who would not otherwise, it has a role," she says. "However, I am troubled that HIV status is learned over the telephone. If a person receives a positive result, there is no guarantee they will call the counseling telephone numbers."

Theresa Durham, a certified HIV counselor at the state-sponsored Monmouth Regional Screening Center in Neptune, is wary of the reliability of kits. She knows of ten clients who used home HIV collection kits and received false positive results. "They came to me devastated, and I said, 'Hold on. Let's find out what is going on here.' When the patients were retested, their results were negative."

The question may be whether the HIV home tests Durham's clients used were approved by the FDA, which cautions that unapproved home HIV kits do not come with any guarantee for accuracy, nor is there a documented history of reliable results.

FDA approval of home test kits

Generally speaking, when the FDA reviews applications for home test kits, it examines how the test works, its accuracy, and consumers' ability to test themselves and properly interpret results. For example, when evaluating the ProTime Microcoagulation System, a home prothrombin time (PT) test for patients taking the blood thinning drug warfarin, the FDA examined manufacturer's data on 84 patients at four clinics. Patients were tested by health care workers using a professional laboratory PT test and also tested themselves at home; results were comparable. The system, approved for home use by the FDA in March 1997, is available by prescription and under a doctor's supervision.

The two FDA-approved home HIV collection kits now or previously on the market have reported high levels of accuracy. When the Confide® HIV Testing Service was approved in May 1996, the FDA reported its sensitivity, or ability to detect positive virus infection, was 99.9 percent; its specificity, or ability to indicate absence of virus infection, was nearly 100 percent. Based on those findings, the agency would expect only 1 person in 1,000 to receive a false positive result. A clinical study of the Home Access™ HIV-1 Test System showed that blood spot tests were in 100 percent agreement with venous results.

Nonetheless, when Durham speaks to high school and college students, she does not recommend HIV home collection kits. "It's not about us losing clients," she says. "In fact, many people who use home kits come to us for retesting, regardless of the original result. Even so, if you thought you might receive bad news, wouldn't you want an arm around you?"

Ironically, Confide®, the first home HIV collection kit to receive FDA approval, was taken off the mar-

Home testing for HIV

"The Home Access™ HIV-1 Test System is only a year old, and many people aren't aware of its benefits and how easy it is to use," says Kevin D. Johnson. "Our sales and distribution are increasing each month."

The Home Access™ system begins with the user registering an anonymous code number by telephone and answering demographic and HIV risk factor questions, information the company says is for research purposes. Pre-test counseling consists of a 4½ minute recorded message, but users can opt for a counselor. According to Johnson, about 20 percent of callers ask for a counselor during the pre-test component.

The user places a few blood drops on a card, which is sealed and mailed to the Home Access™ laboratory. With the company's \$29.95 Home Access™ test, results are available in a week; the \$44.95 Home Access™ Express promises results in three business days. Negative HIV test results are relayed by a telephone voice response system; positive results are communicated by counselors. In addition to providing information and emotional support, says Johnson, counselors can help users find services through the company's referral database.

Time will tell whether home HIV collection kits become as accepted by the public as home pregnancy tests. The latter can detect human chorionic gonadotropin, a hormone produced when a fertilized egg is implanted in the uterus. M. Kendra Lewis, MD, a Flemington-based family practitioner who provides obstetrical care, says almost all of her prenatal patients have used these tests. "Women are finding out earlier than before whether they are pregnant, and that enables them to begin prenatal care or make decisions about their pregnancies," she says. "I rarely repeat a pregnancy test, unless there's some uncertainty about the home result."

For Sharon Leaming, there was some doubt about her test result. Three or four days after she missed a period, she used a home pregnancy test and waited the instructed amount of time. "There was a very, very faint pink line," she recalls. "I thought it was a positive result, and my husband thought it was negative. I saw my primary care physician, who drew blood, and that test confirmed I was pregnant. I didn't realize that if I had waited a day or so, the pink line would have become darker."

There can be instances where a test might be effective, but not of much worth. Some stores sell a tick test kit, with which people can send ticks to a laboratory for Lyme disease testing. Kathleen Royce, a nurse epidemiologist at Hunterdon Medical Center, says, "I have no doubt that the company offering this service can test the tick—first to see if it's a deer tick, and second, to determine if it carries the organism for Lyme disease. However, only 1 to 3 percent of tick bites result in transmission of Lyme disease. It's much more useful to be aware of a tick bite site so that you can watch for development of characteristic Lyme disease rash and to know the symptoms of early Lyme disease."

With the popularity of home tests on the rise, are there problems with people becoming overly apprehensive about results? "That happens, and when it does, it's my responsibility to help patients put the numbers they've been collecting in perspective," Brody.

NJM

ket by Direct Access Diagnostics, a Johnson & Johnson subsidiary, last June; a lack of consumer demand was the reason given. About a dozen other HIV home test kits are available today, but only Home Access™ HIV-1 Test System has received FDA approval. And Home Access Health Corporation remains firmly committed to its home test kit product, says Kevin D. Johnson, the company's director of communications.

DIAL THIS ONE NUMBER FOR INTENSIVE OFFICE CARE



973-763-7394

TOTAL OFFICE SET-UPS
REORGANIZING OF YOUR OFFICE
HIRING & TRAINING OF PERSONNEL
SELLING OF PRACTICES
FEE SCHEDULE UPDATES
BILLING & COLLECTIONS
ICD & CPT CODING UPDATES

MARY ANN HAMBURGER
A S S O C I A T E S

Office management not handled efficiently, can be the most stressful part of your practice. Let us handle it for you.

THE RIGHT PRESCRIPTION FOR YOUR CALLERS



Message-On-Hold Systems

Use your telephone music-on-hold feature to

- Promote Services*
- Reassure Callers*
- Educate & Inform*
- Encourage Referrals*

HOLDCOM

Serving the NJ Healthcare Industry Since 1987

Call 1-800-666-6465

<http://www.holdcom.com>



Excel Business Park

501 Prospect Street

Unit 96

Lakewood, NJ 08701

Phone: 732-886-0600

Fax: 732-886-0911

"The overall effect is total customer satisfaction."

- Medical/Dental Cabinetry
- Nurses Stations
- Reception Desks
- Nourishment Centers
- Medical/Dental Procedure Carts
- Computer Desks
- Monitor Cabinets
- Chart Racks
- Corian® Solid Surfacing
Certified Fabricator #C-5112
- Space Planning/Layout

WORK OF A NONINVASIVE VASCULAR LABORATORY

*Clifford M. Sales, MD, RVT
Joanne N. Gerard, RVT*

Dr. Sales, a member of the Medical Society of New Jersey, is the medical director and Ms. Gerard is the technical director, of The Vascular Laboratory at Union Hospital.

The function of a noninvasive vascular laboratory is to diagnose vascular pathology utilizing ultrasound and plethysmographic techniques. Disease processes affecting any arterial or venous structure, with the exception of the heart, are readily imaged and assessed to determine the presence of vascular disease. Applications of the principles of physics—especially flow dynamics—allow quantification of the magnitude of the disease present. The most common applications of these technologies include the assessment of carotid artery stenosis, venous patency of the extremities, degree of arterial disease of the extremities, and the assessment of disease processes of the aorta and its branches.

Duplex ultrasonography of the carotid arteries has become

the standard of noninvasive techniques to evaluate extracranial carotid circulation. The benefit of carotid endarterectomy in the treatment of carotid artery occlusive disease has been well documented. The need for an accurate determination of the degree of stenosis of the internal carotid artery before risk stratification can be determined has been stressed in all of the studies performed to date. Many centers have replaced arteriography—both conventional and magnetic resonance imaging—with duplex ultrasound as the definitive diagnostic tool to assess carotid arterial circulation. However, one must be certain that the duplex study performed is of high quality and that the laboratory has performed specific validation criteria to document its accuracy.

Another common diagnostic test performed in the noninvasive laboratory is venous ultrasonography. Most commonly performed to rule out the presence of deep vein thrombosis (DVT), this noninvasive technique has become the standard for the diagnosis of DVT.

Venography rarely is used due to its risks and its inability to provide repeat studies in a convenient manner. The capability to routinely study all of the named lower extremity veins allows the experienced technologist to identify the presence of venous thrombus and direct appropriate therapy. Most importantly, duplex ultrasonography allows the physician to perform serial examinations to assess for the propagation of venous thrombosis, thereby providing data that can alter the management of patients with known venous disease.

The proper evaluation of the lower extremity arterial circulation is a unique component of the noninvasive vascular laboratory. While an accurate pulse examination is important in the assessment of the lower extremity arterial circulation, the use of arterial plethysmography, known as pulse volume recordings (PVRs), provides an objective assessment of the arterial system that can be used to compare treatment effects over time. Ultrasonography, most often misutilized to study the lower extremity arterial circula-

tion, provides only an anatomic study of arterial blood flow. PVRs provide a physiologic assessment of blood flow and have a direct correlation to the clinical situation. The ability of a wound to heal or the degree of ischemia can be predicted more reliably with PVRs than with duplex ultrasound.

Assessment of the aorta and its main branches—celiac, superior mesenteric, and renal arteries—are studied reliably with duplex ultrasound. The diameter of the abdominal aorta can be accurately measured to document the presence of aneurysmal dilatation. The ability to follow a patient with a small abdominal aortic aneurysm is made simpler—and more cost effective—with duplex ultrasound than it would be with the use of regular computed tomography scans or magnetic resonance imaging.

Screening for renovascular hypertension can be performed accurately utilizing duplex ultrasound techniques and applying hemodynamic flow principles. The caliber of the renal arteries can be directly visualized and flow velocities of the adjacent aorta and renal artery are compared to determine the degree of renal artery stenosis. Similar techniques are employed to assess the mesenteric circulation (celiac and

superior mesenteric artery) in the management of chronic intestinal ischemia.

The noninvasive vascular laboratory can provide many other clinically useful diagnostic studies. Among these are the assessments for vasospastic disorders of the extremities (Raynaud's disease), thoracic outlet syndrome, and subclavian steal syndrome. Surveillance of grafts that have been placed in the extremities (lower extremity revascularization grafts or hemodialysis access grafts) or in the abdomen are routine functions of the noninvasive laboratory. The ability to examine the deep and superficial veins of the lower extremities to determine the causes of venous insufficiency and varicose veins is an important aspect of the laboratory. The technique of transcranial doppler analysis has assisted in the determination of carotid artery disease—intracranial and extracranial—as well as intracranial pathology such as arteriovenous malformations and hemorrhagic complications.

A new component of the noninvasive vascular laboratory is the ability to diagnose and treat arterial pseudoaneurysms of the extremities. Most commonly seen following arterial punctures for invasive procedures, duplex ultrasonography

has allowed for the accurate diagnosis of these problems.

Recent work in this field has documented success in the ability to thrombose the pseudoaneurysm while leaving the native artery intact. This has eliminated the need for surgical procedures, which can be difficult, and, at times, accompanied by significant blood loss.

The ability of the noninvasive vascular laboratory to perform these studies in a reliable and accurate manner is a function, primarily, of the laboratory personnel. The technologists must be well schooled in the techniques and have a thorough understanding of vascular disease processes. The physicians interpreting the studies must be equally adept and have an appreciation for the limitations of the studies performed. Quality assurance must be a regular feature of the laboratory with appropriate correlation to more invasive studies and operative findings. Recognition by the Intersocietal Commission for the Accreditation of Vascular Laboratories should be a minimum requirement for any functioning noninvasive vascular laboratory. Accurate studies can be assured when the technologists and physicians work together to assure the highest quality of studies performed for appropriate indications.

NJM

TRENDS

FOR PHYSICIANS FRUSTRATED
WITH MANAGED CARE

Neil E. Weisfeld, JD, MSHyg

Mr. Weisfeld is deputy executive director, MSNJ.

For the first time, physicians in New Jersey now can invoke a full range of protections designed to enhance patients' access to care and to the quality of care. These protections are so comprehensive as to afford physicians a real chance to regain professional autonomy in a managed care environment.

What may be missing, so far, is action by physicians to implement these protections. Here are a few tips for overcoming the confusion, uncertainty, and skepticism that attend any government initiative—including the New Jersey managed care regulatory initiative that, in 1997 alone, saw adoption of tough new HMO regulations, adoption of the Health Care Quality Act, and an enforceable agreement by most of the state's leading HMOs to pay claims promptly.

1. Recognize your clout as a physician. Clinicians have power; they are not at the mercy of clerks and insurance executives. The voice of medicine is the voice that has prevailed in our state Legislature, in the executive branch of government, and in the news media. State officials are committed to developing a system that is acceptable to the med-

ical community, on the theory that a system that is unacceptable to health professionals is, in fact, broken.

2. Treat the patient and family as your ally. You have a duty to explain all appropriate diagnostic and therapeutic alternatives. You have the right and the obligation to assist patients in submitting complaints and appeals in response to adverse action by an HMO or other state-regulated insurance carrier. Rest assured that any effort by a managed care organization to penalize you for serving as a patient advocate will bring the full wrath of the state down upon your would-be tormentor, and indeed, there is little or no credible evidence of such retaliation to date.

Be careful, though. Do not waste your time and valuable prestige denouncing the HMO to your patients. This truly could violate your provider contract and alienates patients.

3. Remember, moreover, to treat the patient as a valued person. Under managed care, patients find it easier than ever before to migrate from one practitioner to another. And, increasingly, patient satisfaction survey results are used to select physicians for network participation, to evaluate physicians in con-

sumer-friendly formats, and to determine physician compensation levels. In general, patients admire and trust their physicians, who continue to dominate consumer trust surveys.

4. Understand that you have leverage with the HMO or other carrier based upon your clinical competence and your attractiveness to patients.

Third-party payers in New Jersey have nearly run out of ways to punish or to avoid physicians who insist on providing high-quality care. Under a state Supreme Court decision, payers face potential liability for denials of necessary medical care, and such denials also are acceptable within the new regulatory apparatus. Payers may not boycott or refuse to contract with quality-minded physicians, because network selection must be done by committee, with appropriate representation.

Payers may not steer patients away from certain physicians in the network, because patients have open access to network physicians who are accepting new patients. Nor can payers terminate physicians arbitrarily; rather, in the most hard-fought protection of all, terminated physicians have a right to a hearing and to a written reason for termination.

Finally, employers and other purchasers are insisting on widespread choice of physicians, so that carriers that exclude popular and highly competent physicians will lose business essential to their survival.

5. Master clinical protocols. In our state, medical necessity remains the standard for coverage. Denials may be made only on the basis of professionally accepted protocols, which you as a clinician have a right to review. Indeed, companies may develop their own protocols only with the active participation of representative physicians in the network, so you may wish to volunteer to serve on relevant committees.

6. Challenge incorrect denials. Timely decisions by utilization management authorities are mandatory, and must be made by a physician, to whom you have access. The three-stage appeal process is designed to be user-friendly.

7. Maintain an impressive professional demeanor. Insulting communications toward medical directors and subordinates are counterproductive. The most successful communications include matter-of-fact references to clinical protocols, previous documented communications, regulations, the patient record, and the provider contract. Like your own, the HMO workforce consists mainly of conscientious

people trying to do a job under adverse conditions.

8. Consider nontraditional approaches to resolving your grievance.

If many of your patients are covered by a health plan negotiated by a single employer, call the employer's human resources manager to describe how the plan's actions are reducing employees' access, choice, quality, satisfaction, and timeliness of payment. If your provider contract authorizes arbitration, try arbitration; you may be pleasantly surprised to learn that arbiters usually side, at least in part, with the complaining party. Above all, freely use the complaint and appeal system that is the bedrock of the state's regulatory system.

9. Rely on your own internal quality management program.

If your practice is running into substantial reimbursement problems with multiple third-party payers, retain an outside expert to review your claims processing system. Use patient questionnaires to determine what your patients like most and least about your practice. Don't be afraid to hire an occasional and highly recommended consultant, accountant, information system analyst, marketing expert, attorney, or financial manager when a problem presents itself.

10. Use resources available to you as an MSNJ member. Currently, those

resources include the HMO Complaint Packet, managed care patient brochure, contract review, legal consultant network, access to the MIIX Healthcare Group consultants, www.msnj.org web site, Physician Finder listing, free AMAP accreditation, smoking cessation guide, and a streamlined association structure that has achieved remarkable influence with state regulatory authorities, the American Medical Association, and other policy-making organizations.

Of paramount importance is physicians' frequent use of the complaint and appeal system, laid out in MSNJ's carefully developed HMO Complaint Packet. As noted at the outset, the protections need to be used to affect and strengthen patient care. Simply put, the complaint packet enables MSNJ to bring to bear the forces of a unified, prestigious profession to improve the system.

This appeal to physicians' resourcefulness offers no panacea, of course. Ultimately, the medical profession also is affected by the law of supply and demand. Consider, too, that effective managed care regulation is a new endeavor, crude in its infancy, that surely will be refined and enhanced during the years ahead. Your cooperation will speed the enhancement and will improve the system for your patients, your staffs, and yourselves.

NJM



Stuart M. Hochron, M.D., Esq.

Physician Legal Representation

- Group Practice Formation
- Physician Litigation
- Federal Regulation
- Board of Medical Examiners

Practicing Physician, Twenty Years
Clinical Professor, UMDNJ-RWJMS
Research as Highlighted on CNN
AMA Physician Referral Service
Partner, Richmond, Hochron & Burns



phone: (732) 821-0200 fax: (732) 422-9444 e-mail: MDLAWSMH@aol.com

209 North Center Drive North Brunswick, New Jersey 08902

I'm on the MSNJ Physician Finder.

Are you?



*Carl Restivo, Jr, MD
MSNJ President*

The Physician Finder:

- Showcases and markets my practice.
- Offers a comprehensive overview about my office.
- Presents detailed information for referrals.

The MSNJ Physician Finder is an electronic directory of active MSNJ members. You can find the Physician Finder on MSNJ's web site:

www.msnj.org

For more information about the Physician Finder
call MSNJ, 6709/896-1766 ext. 259.

The **MSNJ Physician Finder** is the place to turn
for information about MSNJ physicians.

REPORT CARDS HOLD HMOs ACCOUNTABLE

Len Fishman

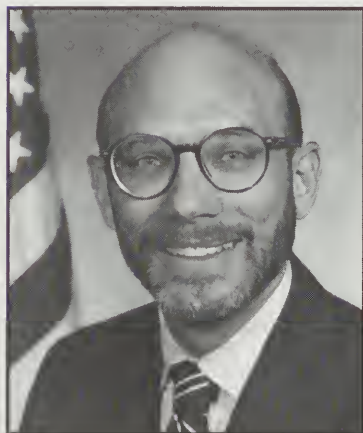
Mr. Fishman is the commissioner, New Jersey Department of Health and Senior Services (DHSS).

Health maintenance organizations (HMOs) have grown explosively in our state. Today, one in three insured New Jersey residents is enrolled in an HMO. Despite this growth, most consumers know little about the performance of their HMO plans.

New Jersey has emerged as a national leader in protecting HMO patients and holding plans accountable. Our state has strong consumer protections, thanks to new HMO regulations, which contain a patient bill of rights. We have the Health Care Quality Act, which extends and expands those consumer protections to all forms of managed care.

New Jersey now is the second state in the nation to hold HMOs accountable through an HMO report card. For the first time, New Jerseyans enrolled in HMOs, or those considering

enrollment, have reliable and accurate information about how HMOs are doing at providing care, including important preventive care. And for the first time, New Jerseyans can see how their plans are regarded by their own members.



Len Fishman

We had three goals in mind when we set out to create an HMO report card: to give consumers and businesses reliable information to help them choose the HMO that is right for them; to motivate HMOs to improve performance by allowing them to compare themselves with their peers; and to help DHSS monitor HMOs' impact on public health.

Our report cards look at patient care and consumer satisfaction. For performance measures, we selected a measuring system used by the National Committee for Quality Assurance (NCQA), the leader in measuring HMO quality. To gauge consumer satisfaction, we polled nearly 6,000 HMO members from across the state to find out what patients thought of their plans.

We found that while HMOs did well in some important areas, when it comes to preventive care, there is much room for improvement. Prevention is the stock and trade of HMOs. It's in their name: health maintenance organization. In these important areas, HMOs should be doing better.

We asked HMO members to rate their plans on a scale of zero to ten, with zero being the worst and ten being the best. Comparisons are based on each plan's average score for this question (Figure 1).

We then asked patients whether it was hard or easy to find a doctor they liked, and

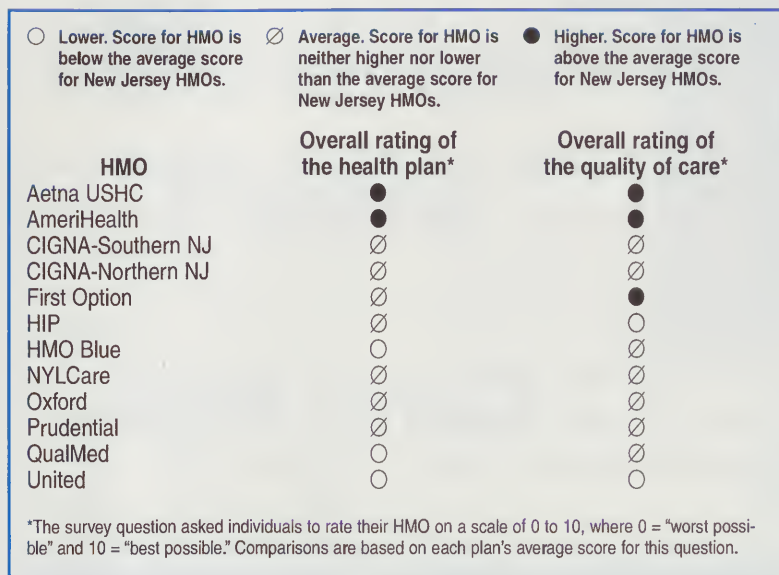


Figure 1

whether they had trouble getting referrals to specialists. Eighty-five percent of patients said it was easy to find a doctor with whom they were happy, while 79 percent of HMO patients said it was easy to get referrals to specialists.

The performance of HMOs in the area of preventive care was disappointing. For example, we know how important immunizations are for keeping children healthy. Yet the HMO statewide average for immunizations is 57 percent. Let me put that rate in perspective. The Centers for Disease Control and Prevention (CDC) says our statewide immunization rate is 78 percent. To its credit,

NCQA uses a tougher standard than the CDC. NCQA looks at 11 immunizations (4 DPT, 3 polio, 1 MMR, 1 influenza B, 2 Hepatitis B) instead of 8 the CDC measures (4 DPT, 3 polio, and 1 MMR).

NCQA also sets a stricter time frame for when vaccines must be given. Still, our 57 percent immunization rate is well below NCQA's 67 percent average for the mid-Atlantic states (New York, Pennsylvania, and New Jersey), and NCQA's national rate of 65 percent (Figure 2).

We asked how many pregnant HMO members received prenatal care during the first three months of pregnancy. The HMO statewide average was 81 percent, below the NCQA mid-Atlantic states' average of 83 percent and below the national rate of 84 percent. Again, this measure shows us HMOs have work to do.

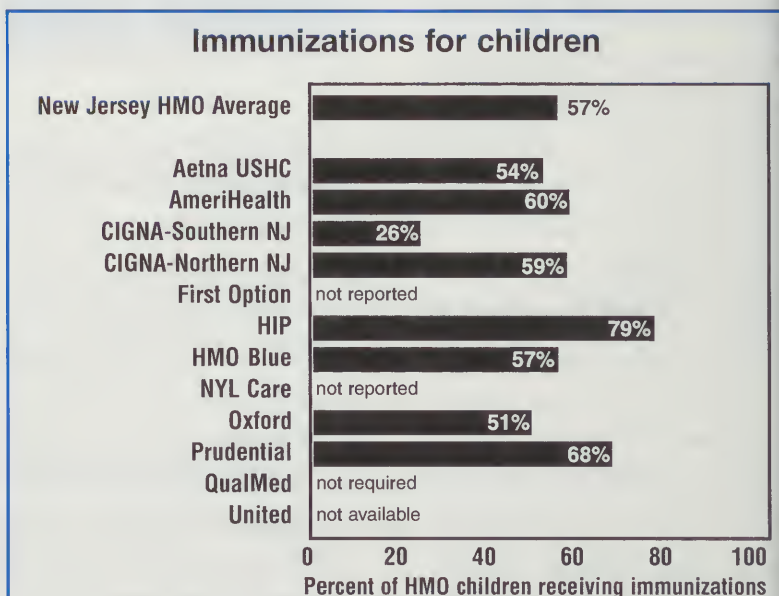


Figure 2

Testing for breast cancer

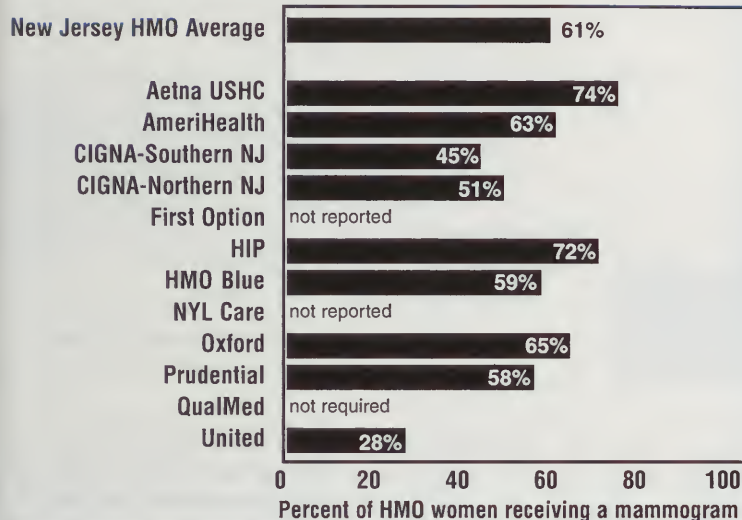


Figure 3

What percent of new mothers in HMOs received followup checkups? We found that an average of 43 percent of new mothers saw a doctor within six weeks after delivering—below NCQA's mid-Atlantic states average of 54 percent, and the national average of 57 percent. The HMO statewide average for women screened for cervical cancer is 64 percent, again below the NCQA mid-Atlantic region and national rate.

One of the positive features of HMOs is that unlike fee-for-service plans, HMOs can be held accountable. We can use these measures to see how plans are doing at meeting

important public health objectives. For example, our "Healthy New Jersey 2000" goal for breast cancer screening is 60 percent. Our report card found that 61 percent of women in HMOs (between the ages of 52 and 69 years) were screened for breast cancer within the past two years (Figure 3). This figure is slightly better than the goal, but not as good as we'd expect from HMOs, which pride themselves on focusing on preventive care.

This report card provides consumers, employers, and benefit managers with information that can be useful in making decisions. It gives HMOs a way to see how they're doing

compared with their peers, and tells HMOs we're holding them to their promise of attention to preventive care.

Twelve HMOs in New Jersey were included in the member satisfaction survey based on the size of their membership (2,000 or more) in the fourth quarter of 1996. The 12 HMOs included in this report make up 98 percent of commercial HMO membership. Our performance measures were based on members enrolled for at least one year. One plan didn't meet that 2,000 membership requirement for the time frame and was not required to report. Two other plans failed to produce accurate performance data and are not included in the performance measures. Medicare and Medicaid members were not included in the polling.

For a copy of the HMO report card, contact the Office of Managed Care, P.O. Box 360, Trenton, NJ 08625. Telephone: 1-888/393-1062. Fax: 1-609/633-0807. The report card also is available at the DHHS web site, www.state.nj.us/health.





HEALTH LAW PRACTICE

*representing healthcare providers,
including physicians, physician groups, other
clinical professionals, academic medical
centers, multihospital systems, independent
acute care and specialty care hospitals,
ambulatory care centers, and nursing and
assisted living facilities*

For more information or a copy of our
New Jersey Health Law Advisory,
please contact
Alma L. Saravia
51 Haddonfield Road
Cherry Hill, NJ 08002 • (609) 488-7300

DUANE, MORRIS & HECKSCHER LLP

A PENNSYLVANIA LIMITED LIABILITY PARTNERSHIP

Cherry Hill and Newark, New Jersey
with additional offices in
Pennsylvania • New York • Washington, D.C.
Delaware • Florida

Lower Malpractice Premium with Managed Care?

The Joseph A. Britton Agency can help make it happen! If Managed Healthcare is making you consider joining:

- an IPA,
- a large single or multi-specialty group,
- a staff model HMO, or
- a PPO

your professional liability insurance cost could actually go down!

With over 25 years of experience, the Britton Agency has proven exceptional in packaging malpractice insurance. Our professional staff and size ensure you the benefits of specialized and personal service while offering you insurance at the lowest cost.

Call us today for a free consultation.
Your career can depend on it!

Joseph A. Britton Agency, Inc.

Healthcare & Professional Liability Insurance
855 Mountain Avenue, Mountainside, NJ 07092
908-654-6464 • Fax 908-654-1422 • 1-800-462-3401



Druker, Rahl & Fein

Business Consultants
Certified Public Accountants

We have your prescription to profitability

We're Druker, Rahl and Fein, the accountants and advisors
to physicians and health care providers.

...Managed Care..Government Regulations
..the industry is changing..quickly.

How will these changes affect your practice?
You have questions and you need answers.
Our medical services experts will assist you
in developing a strategy to
succeed in this dynamic environment.

Leaders in:

Cost Accounting • Strategic Planning • Group Practice Formation • Tax
Managed Care Analysis • Practice Valuations • Practice Management

200 Canal Pointe Boulevard • Princeton, NJ 08540-5998 • 609-243-9700 • FAX 609-243-9799

Contact Robert J. Rahl, CPA

Elin A. Gursky, ScD

THE ENVIRONMENTAL HEALTH OF OCEAN COUNTY

Dr. Gursky is senior assistant commissioner, Public Health Protection and Prevention Programs, New Jersey Department of Health and Senior Services (DHSS).

In the practice of community medicine, public health practitioners follow the same steps as their medical practitioner colleagues. Thorough history taking and administration of diagnostic tests are just some of the systematic steps taken to address the health of a population.

The New Jersey Department of Health and Senior Services (DHSS) receives many queries regarding perceived "excesses" of disease, usually cancer. DHSS is home to several programs whose specialities cover these concerns, including the Office of Cancer Epidemiology, the State Cancer Registry, and the Division of Environmental and Occupational Health. The objectives of these programs are to analyze rates of cancers, and to evaluate confirmed or suspected hazardous sites to validate the presence of "completed exposure pathways." This establishes and quantifies a route of

exposure from a contaminated area through a medium to an individual.

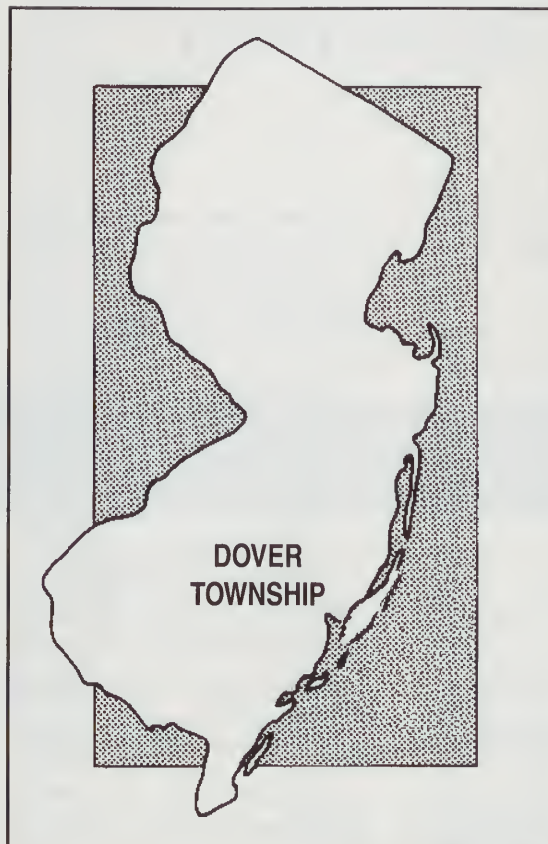
DHSS first met with members of the Dover Township section of Toms River (Ocean County) community in March 1996, when 1,400 persons voiced concern, anger, and fear over childhood cancers. Following this meeting, a "Public Health Response Plan" was written in conjunction with the Federal Agency for Toxic Substances and Disease Registry (ATSDR). The Plan was to serve as a blueprint for a strategy of concurrent environmental assessment, community history taking, and evaluation. The chemical production, historical inventory, and disposal practice of industrial interests in proximity to Dover Township were assessed in conjunction with the most indepth municipal water system analyses and other environmental testing ever undertaken in New Jersey.

Dover Township is home to two sites on the U.S. Environmental Protection Agency (EPA) National Priorities List ("Superfund"). These are the Ciba-Geigy Corporation and Reich Farm sites. In addition, there are numerous other areas of contamination and potential exposure routes.

Ciba-Geigy was an active chemical manufacturing facility that produced synthetic dyes, pigments, and epoxy resins from 1952 to 1990. Waste materials from the manufacturing process were disposed of both on- and off-site, with some materials discharged directly into the Toms River prior to the enactment of environmental regulations. A pipeline constructed in 1966 to carry waste from the plant to the Atlantic Ocean and running beneath residential and commercial areas of Toms River was known for several "breaks" during its 25 years of use.

Reich Farm occupies a site of approximately three acres on which 4,500 drums of chemical waste were dumped by an independent waste hauler contracted by the Bound Brook-based Union Carbide Corporation in 1971. The wastes included organic solvents, residues, and other products generated during the manufacture of organic chemicals, plastics, and resins.

Both Superfund sites are being cleaned up by the EPA, which has included on-site clean up and soil removal. However, documented groundwater and sediment contamination from volatile organic com-



pounds, heavy metals, and other materials resulted in removing many homeowners from private wells, and installing air strippers to the municipal water system in the late 1980s.

The process of testing has included standard methods of analysis as well as non-standardized research techniques. Dover Township's public water supplies, routinely tested for 85 potential contaminants under the state and federal Safe Drinking Water Acts, were tested for 60 volatile organics, 35 synthetic organics, 90 pesticides, 60 semi-volatiles, 13 metals and non-volatiles, and

high molecular weight organic chemicals; far exceeding the standard state and federal water testing requirements. Slight elevations of copper and lead levels in a few of the public schools have resulted in a brief flushing regimen prior to the start of the school day. By eliminating the usual holding time for water subjected to radiologic testing, a short-lived radium 224 decay chain was identified as contributing to the nat-

urally occurring radioactivity, which characterizes much of southern New Jersey. Dimers and trimers of a previously unidentified and unregulated waste product of styrene acrylonitrile polymer plasticizer have been found in two municipal wells. Both wells have been taken out of the distribution system and are being treated to remove the "trimer." Toxicity testing of this compound will be initiated shortly.

Validating the community's concern was an essential component of the Public Health Response Plan. For the 17-year period 1979 through 1995 (1979 is the first complete year

of data available from the New Jersey State Cancer Registry), results have been compiled and reviewed (Table).

Along with the partnership of local, state, and federal agencies, DHSS has engaged the assistance of 20 leaders from within and outside New Jersey. This panel, consisting of pediatricians, neurologists, oncologists, epidemiologists, and tumor classification experts, has provided guidance and feedback on several key steps in interpreting the cancer incidence data and developing the subsequent phases in the investigation. In the presence of specific kinds of elevated childhood cancers and the history of groundwater contamination, DHSS is developing a case-control epidemiologic study to explore potential risk factors associated with the elevated brain, central, and sympathetic nervous system tumors, and leukemias. With a relatively small sample size ("n" approximately 35 cases), the study design will use a four-to-one overmatch methodology to improve statistical power. Controls will be selected from grade cohorts (at year of diagnosis) from the Dover Township Regional School System. Letters of invitation to participate in the study were sent to residents in early January 1998. Trained cancer interviewers from DHSS will conduct indepth telephone interviews designed to gather residential, gestational, med-

ical, recreational, and other historical information. A draft report of this study is targeted for December 1998.

Hundreds of communities each year across the country perceive "clusters" of disease, with cancer and non-cancer endpoints. Where systematic data collection procedures, such as cancer registries and birth defect registries, exist certain incidence comparisons can be made. However, even meeting the test of "statistical significance" does not a priori suggest the appropriateness of a full-scale epidemiologic study. Great variability of data plague the small sample sizes seen when individual communities raise concerns. (In New Jersey, official cancer reports are analyzed at the county, not municipal, level in large part.)

Exacerbating the issue of interpreting small numbers is the insufficiency of information regarding etiology. Community beliefs and theories about causality have to be addressed in an approach consistent with biologic plausibility. More literature is available that documents associations between certain cancers and occupational exposures, then that which exists to explain pediatric cancers such as acute lymphocytic leukemia and neuroblastoma. Molecular and genetic approaches will augment population-based studies

Table. Cancer incidence from 1979 through 1995. Birth through age 19 years of age at time of initial diagnosis.		
	Number of cases expected	Number of cases observed
Ocean County	340	358
Dover Township	67	90*
Toms River	14	24*

Further analysis of the data indicated:

- Neuroblastoma and astrocytoma were elevated at the county level.*
- Dover Township was the only municipality in Ocean County in which overall childhood cancer incidence was higher than expected.*
- Leukemia incidence was elevated in females, particularly under age five.*
- Overall childhood cancer incidence was elevated in the Toms River section of Dover Township. This elevation was seen in female children under age five, especially for leukemia and brain/CNS cancer.*
- The cancer trend for Toms River for the years in question ranges from zero to four cases per year, with no specific pattern that can be interpreted.

*Indicated statistically significant elevations.

to understand childhood cancers and potential environmental triggers.

The road to diagnosing a community is multi-step and frequently concludes by generating more questions. Although large-scale cluster studies often are the exception rather than the rule, previous research always serves as a benchmark.

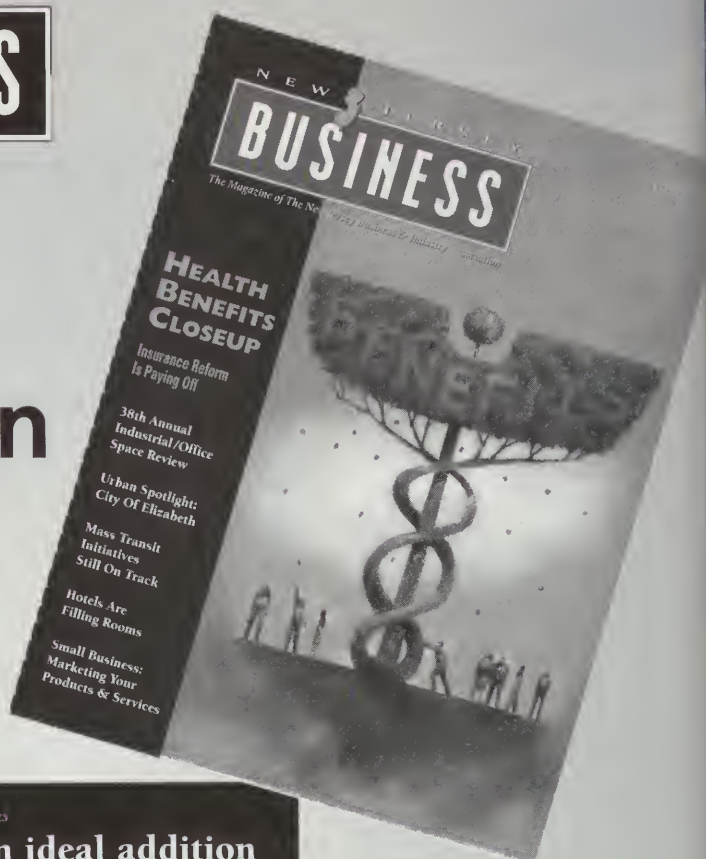
Because the investigation in Dover Township is considered a "sentinel study," congressional and state appropriations have been authorized. Growing national concerns regarding increasing rates of childhood cancers, as well as suspicions about the role of environment and health, have focused the eyes of the country on Toms River.



NEW JERSEY BUSINESS

The Magazine of the New Jersey Business & Industry Association

Your Subscription for Healthy Business



Subscribe today.

NEW JERSEY BUSINESS is an ideal addition to your waiting room or office.

SAVE up to **45%** Off Our Cover Price

Name (please print)

Company (if applicable)

Address

City State Zip

Telephone

Type of Business

First Issue **FREE**

- ☐ **1 Year \$20** (12 issues)
(save 26% off Cover Price)
- ☐ **2 Year \$33** (24 issues)
(save 39% off Cover Price)
- ☐ **3 Year \$45** (36 issues)
(save 45% off Cover Price)
- ☐ **Payment Enclosed**
- ☐ **Bill Me**

NJ MED-97

NEW JERSEY
BUSINESS

The Magazine of the New Jersey Business & Industry Association

New Jersey Business magazine
310 Passaic Avenue, Fairfield, NJ 07004
Tel: 201-882-5004 Fax: 201-882-4648 e-mail: mail@njbmagazine.com <http://www.njbmagazine.com>

Diane Haring Cornell

HELPING VICTIMS OF RAPE: A PROGRAM CALLED SANE

Beverly Warwick, RN, NPC, says she volunteered to become certified as a sexual assault nurse examiner because of the way a friend was treated when she was raped several years ago, "It was a tough road for her and it was very difficult for her to come forward. She had to go to the emergency department to be examined, and that made it even worse." Warwick says her friend, as with many victims of sexual assault, languished in an emergency department waiting room for eight hours as others were triaged ahead of her. "She spoke to one person, then another, then someone else got involved and she had to retell what happened yet again. It was a terrible experience to have to relive and she was made to relive it every time she was forced to retell her story," Warwick says.

A pilot program in Monmouth County seeks to rectify all that and provide a more sensitive, supportive atmosphere for survivors of sexual assault and to improve the

quality of forensic evidence and information collected. Due to inconsistent training of emergency department staff, the quality of evidence gathered often has been poor. Since the survivor usually is the only witness to the crime, successful prosecution in sexual assault cases greatly relies on the collection of physical evidence and the documentation of medical trauma to substantiate an allegation or strengthen a case.

The program, based on a similar one in Tulsa, Oklahoma, utilizes specifically trained and certified registered nurses to perform examinations and collect evidence from survivors of sexual assault. The hope is to expand the project to other counties in the state, says Jennifer Beck, legislative director for Assemblyman Joseph Azzolina, whose office cosponsored the bill that established the two-year model project known as SANE: Sexual Assault Nurse Examiner. The bill became law in July 1995, establishing the program under the direction of the State Attorney General's Office of Victim/Witness Advocacy.

Similar SANE programs around the country have been directly related to an increase in the number of sexual assaults reported (it is estimated that

only one in ten sexual assaults is reported to police), specimen collection improvement, and an increase in the conviction rate, Beck says.

The first SANE program was started in 1976 in Memphis, Tennessee; it wasn't until the mid-1980s that individual programs across the country came together. Today there are more than 85 SANE programs oper-



Assemblyman Joseph Azzolina cosponsored the bill for the SANE project.

ating across the United States. Most are based in health care facilities, while others exist as part of community-based sexual assault programs, in health departments, or based in prosecutor's offices like the one in Monmouth County.

The Monmouth County SANE program works closely with the 52 local police departments in the county and the

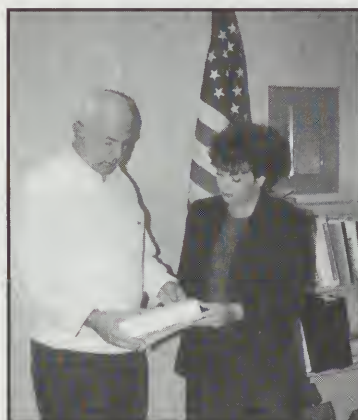
Women's Crisis Center of Monmouth County. The number of reported rapes in New Jersey in 1996, the last yearly figure available from the state's Uniform Crime Reporting Act, was 1,972, a 2 percent increase over the previous year's figure of 1,924. The total number of arrests for sexual offenses, which is defined as improper sexual contact that is not rape or prostitution, was 2,080 in 1996.

When a sexual assault is reported, a SANE nurse is contacted by the program coordinator to report to a designated examination site at either Jersey Shore, Riverview, or Monmouth Medical Centers. The sites are equipped with a counseling area, an examination room, and a shower facility. Once at the hospital, the SANE nurse will meet the victim, police officer, and counselor from the Women's Crisis Center. The examination is performed immediately and usually the whole process including the police investigation and counseling is completed within two to four hours.

"More importantly the program helps victims feel safer and more in control with what's happening," says Warwick, who went through a 40-hour training program at Rutgers University to be a volunteer. Fifteen nurses work with the program; more nurses are needed. Nurses are assigned six 12-hour shifts a month when

they are on-call. Since Warwick began in June she says she has gone out on ten calls in a four-month period.

Warwick says, "Another aspect is that the victim is not registered in the emergency room, she is registered as an outpatient so not everyone knows she has come in because of a rape." She says



Eileen Allen, SANE program coordinator for the Monmouth County prosecutor's office and Robert Ferguson discussing the sexual assault evidence kit.

the program conducts case reviews monthly to offer the opportunity to modify or review the program's protocol.

Eileen Allen, RN, BSN, is the SANE program coordinator in the Monmouth County prosecutor's office. She says emergency room physicians were the first to applaud the program's efforts. "With the program, physicians are removed from the role of witness. Now evidence is collected more consistently and adequately," notes Allen. "The SANE nurses are

trained in forensic photography, evidence collection, and packaging and documentation—all training the ER doctors and nurses never had."

The program's three-person team tries to meet all the survivor's needs. A rape-care advocate offers support and counseling information; a SANE nurse interviews the survivor and ascertains injuries (if needed, the victim is sent to the ER for treatment of severe injuries); and the nurse does the physical examination, documents and collects evidence through written notes and photographs, and gives prophylactic treatment for sexually transmitted diseases and postcoital contraception. The police officer gathers information about the assault and informs the survivor of legal rights and the role of the police in the investigation. The victim has one week to make a decision whether to press charges against the attacker.

According to Allen, in the first ten months that the program existed, SANE nurses were called in on 85 cases. In 1996 in Monmouth County, there were 132 rapes and 123 sexual offenses reported, according to John Hagerty of the New Jersey State Police. SANE is involved in cases only if the victim is 14 years of age or older, if the crime is reported within five days of its occurrence, and if the assault occurs within Monmouth County.

PHYSICIAN PRACTICE MANAGEMENT COMPANIES MAY OFFER RELIEF

Patricia A. Costante

Ms. Costante is chief operating officer for the Medical Inter-Insurance Exchange (MIIX) Healthcare Group, one of the MIIX group of companies.

If you've had enough of managed care and are looking for the kind of traditional patient care that seems to have disappeared from modern health care, consider selling your practice to a physician practice management company (PPMC).

PPMCs are independent companies that offer working capital, plus critical information processing, and administrative, legal, financial, and business services physicians need to survive under managed care. In this new paradigm, profits almost certainly will be derived from the kind of administrative efficiencies PPMCs can deliver.

According to the Sherlock Company of Gwynedd, Pennsylvania, PPMCs are growing at 25 to 30 percent per year, yet only about 3 percent of physicians are under contract to a PPMC. With physicians, hospitals, and pharmaceutical

companies looking for a better way to pool capital and resources, this number is expected to rise geometrically.

Today, PPMCs are employing physicians and delivering high-quality medical care as well as a growing number of ancillary services across the country. The Bernstein Report of December 1996 cited the value of the physician services market at some \$200 billion with expectations for substantial growth in the next ten years. The report also stated that revenues of this multi-billion dollar PPMC industry grew 49 percent, reaching almost \$10 billion annually. Driving this exponential growth is the dramatic return on investment generated by high-quality, cost-effective, and efficiently run medical practices under PPMC ownership. These days, extremely high price/earnings ratios—many times the overall market average—and the potential for even higher sell-offs of PPMCs are attracting significant venture capital, providing the means to maintain this double-digit growth.

The best known PPMCs are the large, publicly traded com-

panies, such as PhyCor, MedPartners, FPA Medical Management, Coastal Physician Group, American Oncology Resources, and Pediatrix. While each may focus on a specific region or medical specialty, these PPMCs have an almost insatiable appetite for mergers and acquisitions. They have been making deals with pharmaceutical companies to become involved with clinical trials and buying into managed care companies. In October, PhyCor announced that it had an agreement to acquire MedPartners for an estimated \$8 billion.

Making the deal. If HMOs bring marketing expertise, PPMCs tend to focus on the administrative side of running a practice. In exchange for these services, PPMCs will be looking for ownership of the assets of the practice, a partnership in the practice via a long-term service contract, and typically 15 to 20 percent of the practice revenue. They also may ask for additional compensation from system improvements and ancillary services. The PPMC also will buy equipment and

accounts receivables with cash, stock, and/or notes.

Even the most successful physicians cannot help being enticed by the kind of lucrative deals being offered by PPMCs. They often guarantee long-term employment contracts to physicians, with one-time, upfront cash payments of 50 to 100 percent more than current salaries, stock options, and generous performance bonuses if targets are met. In many cases, the acquisition price alone can be five to seven times the gross annual revenues.

These kind of attractive buy-out packages often give physician practices greater clout in the marketplace, improved access to managed care contracts, more patients, and the opportunity to expand value-added services.

Once the deal is signed, the physician's new partners will typically create a local management team comprised of physicians and PPMC representatives. The PPMC will likely target the information systems first, creating a more business-like infrastructure. Doctors will see dramatic changes in practice management, billing, claims processing, and patient record keeping. Many of these changes are mandated by the corporation and beyond the doctor's control.

PPMCs have a successful track record for changing physician compensation, altering the size and specialty mix of physician groups, applying standardized treatment guidelines, managing costs through group purchasing, and integrating technology. This type of comprehensive re-engineering provides the physician practice with an efficient business infrastructure.

Such restructuring also can lead to 15 to 25 percent increases in productivity, with a potential 40 percent cost savings, reduced insurance premiums, increased income, and security. Increased practice efficiencies will drive higher patient volume, expanded geographic coverage, and enhanced payor/purchaser relationships.

More importantly, physicians will be given the opportunity to withdraw from the stresses of managed care, receive a set fee, work set hours, and get back to patient care.

Checking the fine print. Making the transition from the owner of an independent/solo practice to an employee of a large corporation involves some compromise and loss of control. Physicians may find a



lack of representation on the management team or different views of patient care. Physicians might have problems with the personnel installed in the practice by the PPMC. The salary, tied to performance, also can be jeopardized. If revenue targets are not met, the PPMC can assume more assets, a greater percentage of provider compensation, and a larger management fee.

Although this wave of medical practice buyouts is relatively new to the profession, there are indications that the PPMCs may be growing too fast. Many cases have documented certain weaknesses with PPMCs—for example, poorly trained leadership, lack of strategic planning, too rapid expansion of the practice, and too little investment in building a solid organization.

The revenue growth of any PPMC is based upon continu-

ing acquisition of new physician practices. Therefore, most of their revenues are used for physician buyout packages, rather than strengthening the basic infrastructure of services it offers the physician practices it already owns.

When PPMCs begin to "rob Peter to pay Paul," PPMCs may start to see an erosion of the quality of their operation, which in turn can start to decrease their "predictable" revenue base. Then, these PPMCs must look to other sources of revenue to fuel their acquisitions. These can include selling assets or reducing salaries and bonuses. In some cases, they have even been known to sell off patients. Poorer profits and lower than expected growth causes the stock price to move downward, which then devalues the physician buyout packages.

While this type of gamble may be suitable for those physicians within the practice who are fresh out of medical school because of their limited income potential, or mature physicians headed for retirement, most doctors will be giving up tremendous control over their patients, their practice, and their physician referral base in exchange for a very shaky future. And, when treatment decisions are muddled by prof-

it-minded business imperatives, doctors will find themselves stuck in a long-term service agreement with a stringent non-compete clause that makes it very hard to recover.

Avoiding the pitfalls. If you choose to pursue a partner that appears to have the capital to create a strong administrative/operational infrastructure, take a closer look at the expertise of their management team. Consider their past performance as well as their future direction. Is the corporation interested in aggressive growth? If so, will the physician be one of many practices under the corporate umbrella? What type of role will the physician play after the buyout? How will patients be impacted?

There also could be legal implications to consider. With this type of buyout, there is a potential for physician groups to lose their tax-exempt status. There also may be obstacles to splitting fees with nonphysicians. Your new partnership could be considered in violation of current anti-trust legislation. You also could become implicated for any and all Medicare/Medicaid fraud and abuse by the corporation, regardless of direct involvement. Every physician must work out all the details and ask all the questions before signing on the dotted line.

Generally, it is best to start with the biggest firms by looking for PPMCs that have demonstrated expertise in running large, multispecialty practices, HMO contracting, information technology, and truly adding value to the practice. Any PPMC could very easily sell off a practice to another management firm—without the physician's consent—or simply go out of business, taking with it all hope of cashing in on stocks or options.

If a physician is considering a PPMC, the physician should talk to other providers about buyout experiences, identify any issues that would be considered deal stoppers, look for typical gag clauses and non-compete agreements, and have as much in writing as possible. To thoroughly evaluate the deal, the physician should assemble an objective team of lawyers, accountants, and third-party consultants with the expertise and health care industry knowledge to help evaluate the quality of these agreements.

Doctors will likely need a savvy negotiating partner to help them get the best financial deal in the short-term and safeguard the potential value of a successful medical career over the long term.

NJM

Only MIIX offers



the Toolkit that fits in your briefcase.

Provided by MIIX Financial Services

The MIIX Toolkit, designed specifically for physicians, explains how you can access:

- **MIIX Buying Service** — offering discounts up to 70% on quality medical and office supplies and equipment.
- **Equipment Leasing** — equipment lease financing and lines of credit at competitive rates.
- **Receivables Management** — providing collection of medical accounts receivable.
- **MIIX Capital Management** — investment consulting services for physicians and other high net worth individuals.

To find out more about this powerful resource,
call MIIX Financial Services at

1-800-227-MIIX.

Endorsed by the

Medical Society of New Jersey

MSNJ

M E D I C A L I N T E R - I N S U R A N C E E X C H A N G E
P O W E R F U L P A R T N E R S H I P S



The battle for physicians' rights

Steven I. Kern, Esq
Paul W. Armstrong, Esq

Two cases currently before the New Jersey state Board of Medical Examiners (BME) pose serious potential danger to the physicians of New Jersey. In both cases, the Medical Society of New Jersey (MSNJ) has actively sought to prevent elimination of physicians' rights of a constitutional magnitude.

The first case (*In re W.C.*) is before BME on an application by the attorney general to suspend a physician's license based upon her refusal to allow a BME investigator to rummage through every file, folder, cabinet, and drawer in her offices. The attorney general issued an administrative "Demand for Inspection of Offices" to the physician, demanding to inspect, copy, and videotape literally every piece of paper and item in her offices. Based upon available information, the justification for this warrantless search was a patient complaint that the physician, without charge to the patient, provided a financially strapped patient with a sample of a non-steroidal, anti-inflammatory drug, which had an expiration date stamped on the bottle antecedent to the actual dispensing date. Though BME initially requested only an inspection of

medications, the attorney general issued a Demand To Inspect the physician's entire offices and all of her records. When the attorney general's action was challenged by MSNJ, BME supported the attorney general.

When the investigator appeared at the physician's office, the inspector was advised by the physician's attorney, Steven I. Kern, that the inspector could conduct an inspection of any item in plain view, but that the inspector could not open drawers and cabinets. This advice was provided consistent with established constitutional and case law and the recognition that, pursuant to regulation, a physician has a duty to cooperate with a lawful inspection of her offices.

Unhappy with the attempt to reasonably limit the scope of the inspection, and wanting to conduct a warrantless search of every item in the office, the attorney general brought an Order To Show Cause before BME seeking, among other sanctions, the suspension of the physician's license, were she to continue to refuse to cooperate. Unfortunately, based upon the advice of the same attorney general's office, Bernard Robins,

MD, BME president, signed the Order To Show Cause.

Kern immediately contacted MSNJ's Executive Director Vincent Maressa, and requested assistance. Maressa, surprised by Robins's decision to sign the Order To Show Cause, retained Paul W. Armstrong, Esq to represent the interests of MSNJ in this precedent-setting action of constitutional dimension.

BME heard initial legal argument on November 12, 1997, and on December 10, 1997, and, after granting amicus participation to MSNJ, upheld the attorney general's action, ordered a complete reinspection of the physician's offices and fined her \$1,000.

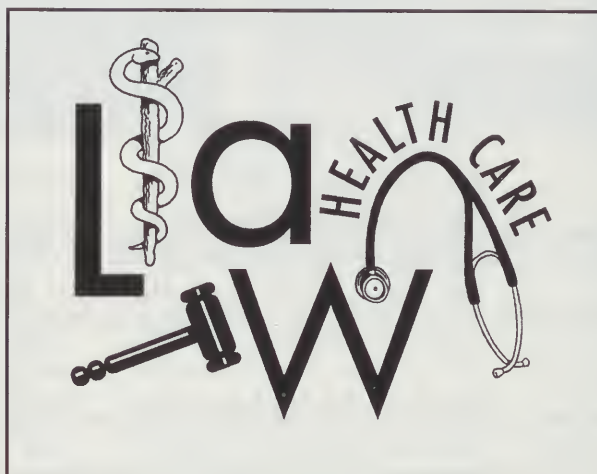
A second case worth serious attention involves an effort by the attorney general to suspend a physician's license based upon the fact that, at separate times in the 1980s, while he was single, the physician engaged in consensual sexual relations with two women. In both cases, the sexual relationships preceded the physician/patient relationship and then renewed some time during the course of treatment. Neither case involved psychiatric treatment. When the case was first brought, the attorney

general alleged that the physician had traded drugs for sex. These allegations were front page news in the physician's community and nearly destroyed the practice.

At trial, after the attorney general rested her case, and before any witness was called for the physician, the administrative law judge dismissed all charges related to allegations of sex for drugs based upon his conclusion that there was not even a scintilla of evidence supporting these totally unfounded charges. Nor was there any evidence that the physician used his position of authority to influence the patients to have sex. To the contrary, the uncontroverted testimony was that the relationships, described as "caring and loving," began well before any medical care was rendered.

Rather than dropping the case at that point, the attorney general, acting on behalf of BME, changed tactics, and argued that in the 1980s it was a *per se* violation of law for a physician to engage in consensual sexual relations with a patient, under any circumstances. The attorney general took this position even though no regulation on the subject of a physician engaging in consensual sexual activities with

a patient existed in New Jersey until 1996. The position of the attorney general also is in direct conflict with another of its recent failed prosecutions. In another case, an administrative law judge found that a physician who engaged in sexual relations with a "significant other" to



whom he also provided medical care, was not engaged in any violation of the Medical Practices Act.

In response to this new tact, the physician called Armstrong and Maressa as expert witnesses for the proposition that no *per se* violation existed in the 1980s, but that sexual relationships between physician and patient, at that time, were only considered unethical if the physician used his authority to improperly impose himself upon the patient. Armstrong was qualified by the judge as an expert in medical ethics and Maressa as an expert

in medical-legal matters. The attorney general's position was provided by Dr. Edmund Erde, a doctor of philosophy who relied for his opinion, in large part upon the Hippocratic oath. When asked by Kern on cross examination for the legal basis to hold a physician to a 4,000-year old oath to pagan gods, Erde could provide none. Ultimately, Erde agreed that virtually none of the language contained in the Hippocratic oath had relevance to today's practice of medicine. Erde also conceded that he personally receives substantial income each year by providing an "ethics course" that BME often requires of errant doctors.

According to Maressa, the issue is not whether a physician in 1998 should have sex with a patient. The issue is whether BME should seek to impose a 1998 standard on actions that took place ten years ago when the issue was far less settled. "This country's constitution has, since its inception, prohibited *ex post facto* prosecutions—prosecutions based upon changes in law occurring after the event. We cannot allow physicians' constitutional rights to be trampled by an overzealous deputy attorney general and an all too pliable BME," said Maressa.

COMMENTARY

Celebrating 50 years of information services

Maureen Pujat, MLS
Deputy Director, New Jersey
Library Association

If you have asked your hospital librarian to get an article on interlibrary loan, chances are that the Health Sciences Library Association of New Jersey (HSLANJ) had a part in providing it. For the past 25 years, 150 health care librarians have been providing information on patient care, education, and research.

In 1972, the buzz words were "information explosion" and federal and state governments were concerned that new research for patient care was not reaching practicing physicians. In New Jersey, government representatives invited a group of hospital librarians to share ideas on how to improve information delivery to hospitals. As a result, the New Jersey Hospital Library Association was formed. In 1978, the name was changed to HSLANJ to accommodate an expanded membership that included other health care institutions.

Sharing interlibrary loans was a key to improving information access. By 1980, HSLANJ had established the New Jersey Health Sciences Network. Hospital libraries had informally exchanged loans for years but HSLANJ was able to develop a sharing mechanism based on borrowing patterns so that no library was overburdened with loans. The only charge for utilizing the network is the HSLANJ institutional membership fee.

HSLANJ and other state library groups who were experiencing the same cutbacks were interested in developing a larger network using the structure similar to the one developed by HSLANJ. By 1986, the Basic Health Science Library Network (BHSL) was operational. The network included 475 members in ten northeastern states. In 1996, over 493,000 loans were exchanged (almost \$5 million worth), with an average saving of \$1,100 per member library.

Forerunner in consumer health information. Long before consumer health information was in vogue, HSLANJ members were advocating and disseminating such materials. An example is the Consumer Library at Overlook Hospital, which opened in 1982, at a time when hospital libraries still were largely regarded as the domain of physicians. Kathleen Moeller, Overlook's librarian, now is nationally recognized as a forerunner in consumer health promotion. This library serves as a regional resource and a model for consumer health services.

In 1983, the New Jersey State Library established a multi-type library network. HSLANJ encouraged its members to join the region-

al library cooperative in their area. Members were able to contribute to consumer health by sharing their expertise with public librarians. Some offered MEDLINE searches to the public and others partnered with neighboring libraries to expand access to medical information to the larger New Jersey community.

Hospitals also benefited because the state network provided better access to business and government material at the time when hospitals were developing product lines and customer-centered services.

Librarian services. From the beginning, HSLANJ has sponsored continuing education programs, providing



HSLANJ President Janice K. Shica, Stratford Campus Library Director, UMDNJ, and Judith S. Cohn, Assistant University Librarian and Director, George F. Smith Library, UMDNJ.

credit from the Medical Library Association. Members can receive and maintain credits necessary for membership in the Medical Library Association's Academy of Health Information Professionals. In 1988, in response to a request from the Medical Society of New Jersey (MSNJ), HSLANJ provided information on standards to be used in MSNJ's continuing medical education accreditation process.

One of the greatest educational challenges in the past decade for librarians and for all health care professionals has

been the HIV crisis. Early in the 1990s, HSLANJ joined the New Jersey Library Association to form the Joint AIDS Task Force. This group offers programs to librarians and the public and publishes *AIDS/Answers: A New Jersey Resource Guide*. HSLANJ distributed a collection of 50 pamphlets, including several in Spanish, to interested libraries. A traveling AIDS display has been exhibited in libraries throughout the state.

Harnessing the Internet for health care. The advent of the Internet has provided librarians with an opportunity to be at the forefront of managing information. HSLANJ supports its members with educational programs for new technology and has developed its own web site (<http://www.njcommunity.org/hslanj>), recognized by New Jersey public librarians as an important tool for accessing health information.

During its 25th anniversary celebration, HSLANJ recognized John W. Sensakovic, MD, as New Jersey Healthcare Administrator of 1997, for his support of Saint Michael's Medical Center Library. Sensakovic remarked that if managed care had been implemented the way it should have been, libraries and librarians would be playing a key role in providing the information that would make health care high quality and cost effective. HSLANJ and its members are committed to fulfilling the role that Sensakovic envisions.

Ms. Pujat is director, Medical Library, Hackensack University Medical Center. Ms. Ryder-Cunningham is library specialist, George F. Smith Library, UMDNJ.

NJM

COMMENTARY

*Our prescription
for online
health care news.*

<http://www.msnj.org>

*Your online source
for health care news.*

**Medical Society of
New Jersey**

Physicians dedicated to a healthy
New Jersey since 1766.

<http://www.msnj.org>

IT'S A CUT-THROAT, DOG EAT DOG, SURVIVAL OF THE FITTEST DRAMA UNFOLDING RIGHT NOW IN NEW JERSEY.

BUSINESS NEWS
NEW JERSEY
March 14, 1997

Coming Your Way On March 3
BUSINESS NEWS New Jersey begins weekly publication with a new design and new features

TOP NEWS
GETTING AHEAD
This morning, a business for the first time in New Jersey...
page 10

DILBERT
The cartoon...
page 10

ALL NEW JERSEY ALL BUSINESS
The business...
page 10

FOCUS SECTIONS
A look at...
page 10

In the cut-throat, dog-eat-dog, survival-of-the-fittest environment of New Jersey business, you need **BUSINESS News New Jersey**. And now that it's a weekly publication it's even more valuable. So, if you're hungry to succeed in New Jersey, devour **BUSINESS News New Jersey** every week.

For your weekly subscription call:
1-888-NJ NEWS 1

BUSINESS NEWS
NEW JERSEY

391 George Street New Brunswick NJ 08901
tel 908.246.7677 fax 908.249.8952 website <http://www.bnjol.com>

Practice MANAGEMENT

Steering the course for medical group management

Jane F. Rider

The Medical Group Management Association (MGMA) was founded in 1925. It is the largest and oldest organization for professionals in the field of medical group practice management and it represents two-thirds of all physicians involved in group practice in the United States. The current membership in MGMA is approaching 20,000 professionals, including administrators, physicians, CEOs, office managers, billing managers, and consultants. These professionals represent over 6,500 member organizations and more than 131,000 physicians. MGMA has representation from the smallest private practice to the largest integrated system to medical school affiliated practices.

MGMA has two inter-related organizations—the Center for Research in Ambulatory Health Care Administration (CRAHCA) and the American College of Medical Practice Executives (ACMPE). CRAHCA provides ongoing research and development in education, new management technology, publications, database services, and demonstration projects.

CRAHCA is funded through private foundations, corporate grants, and self-funding projects, and provides the membership with information on the ever-changing group practice and health care field.

ACMPE nurtures excellence through professional certification. ACMPE provides the forum for a member to achieve certification by taking examinations. A member must pass oral, essay, and objective examinations and maintain a total of 50 continuing medical education credits over a three-year period. When the criteria are met, a member becomes a certified medical practice executive (CMPE). Fellow status also is available to the membership. To



Jane F. Rider

M

Practice management

The Medical Society of New Jersey (MSNJ) and Rutgers, The State University of New Jersey, offer a comprehensive program for today's medical practice manager. The program addresses the three major challenges affecting today's medical practice manager: computers and medical technology; management issues and strategies; and the medical environment. Students completing the program will receive certification and nine college credits for the entire program. For more information, call MSNJ at 609/896-1766.

become a fellow, the member must complete the CMPE criteria and write an original paper accepted by ACMPE.

MGMA gives the office manager the tools to run a practice efficiently and cost effectively in the changing health care environment. Through its 30 various specialty assemblies, MGMA offers national, state, and local meetings, government relations, consulting, placement/career resource center, public relations/communications, and research to help the medical office manager in every aspect of group practice administration.

MGMA's extensive library allows managers to obtain information about health care through a customized search facility. Periodicals such as *MGM Journal*, *MGM Update*, and the

Washington Report keep managers informed on the current issues that affect their practices and jobs. In addition, MGMA provides surveys on physician compensation, membership compensation, and cost surveys. Group practices use these surveys to measure their performance with the rest of the country.

The New Jersey MGMA has over 250 members; it is a well-organized, well-run operation that provides educational conferences and legislative meetings. The New Jersey MGMA has bylaws and a board of directors elected by the membership. Each quarter, New Jersey MGMA mails a newsletter to the membership concerning issues that affect members in the state and at the federal government level. New Jersey committees, such as the legislative and managed care communities, conduct educational meetings for the membership and are active in the politics within the state. Finally, New Jersey MGMA has affiliated with a number of other state organizations such as the Medical Society of New Jersey, the New Jersey Healthcare Congress, and HFMA.

New Jersey MGMA and the national organization partner are providing the membership with the information necessary to help them do their job. In the changing health care world, information is key and MGMA, through national and state organizations, provides such resources.

Ms. Rider, business manager for the Mid-Atlantic Stone Center, in Marlton, is immediate past-president, New Jersey Medical Group Management Association.

NJM

TAKING CARE OF THE ELDERLY: THE UNMENTIONED ABUSES

Joel S. Ross, MD and Joshua R. Shua-Haim, MD

The traditional definition of abuse is the "willful infliction of physical pain, injury, or mental anguish; unreasonable confinement; or the willful deprivation of services that are necessary to maintain a person's physical and mental health."¹ If not carefully searched for, abuse will go unreported.

There have been several excellent reviews of the various forms of elder abuse and neglect.²⁻⁷ A protocol has been established to help assist professionals recognize elder abuse and neglect.⁹

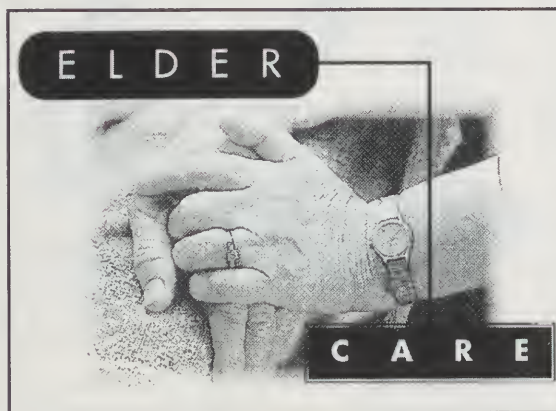
We wish to illuminate covert, but common, types of abuse and neglect inflicted by the managed care industry upon senior citizens.

Enrollments in health maintenance organizations (HMOs) have increased almost tenfold since 1976; the elderly who choose to remain in the traditional fee-for-service plans are shrinking in numbers.¹⁰ One indicator of elder abuse and neglect is the reluctance to provide information.² Patients ask about Medicare HMOs. The most common question being, "Do we still have to pay the Medicare Part B payment of \$46.10?" In our informal polling of patients who have attended more than one meeting, over 75 percent of patients reported they were not told or did not recall being told this amount would be deducted from their social security check.

The ability to remain with their primary physician and specialists also is a prime concern of seniors contemplating joining a Medicare HMO. Recently, one of our patients who attended a recruitment session, asked if we were members of the HMO panel of primary physicians. The HMO representative replied,

"They want too much money, but will join eventually." This is falsifying the facts and should qualify as abuse when defined as "deceit, treachery, coercion, or intimidation used by a person in a position of trust and confidence to gain access to an older person's funds, assets, or property."¹²

Some recruiters use the words "a simple referral letter" or a "preapproval letter is all that is needed" for a referral to a specialist, not explaining the many hurdles and hassles the physician must endure to have such a referral approved. As defined by Wolf and Pillmer, passive neglect is a "refusal or failure to fulfill a caretaking obligation, e.g. nonprovision of health-related services."⁸



Inadequate provision of care by the Medicare HMO industry frequently has been cited as a serious area of concern by enrollees. A 1997 study of Medicare HMO patients suffering a stroke revealed they were less likely to receive rehabilitation and more likely to be placed in a nursing home.¹¹ Using Block and Sinnotts definition of medical abuse of elderly, "the withholding of medications

or aids required," in such Medicare HMO stroke victims most certainly would be examples of such abuse.⁵

The Medicare HMO enrollee is less likely to undergo the traditional "thorough workup" for unusual but curable conditions. We recently cared for a 66-year-old patient with poorly controlled hypertension; he underwent a workup in our office and after two months of testing and retesting, underwent successful removal of a pheochromocytoma.¹² The total cost of the testing, office visits, specialists charges, and hospital bills exceeded \$63,000. Would

a physician under a Medicare HMO contract consider ordering such tests on patients with poorly controlled hypertension? If the answer is no, this would qualify as elder neglect by the definition of "deliberate denial of health-related services."⁸

Physicians under contract with Medicare HMOs constantly are bombarded by case managers from the enrollees HMO to discharge hospital patients quickly. If there are financial advantages to physicians with the shortest lengths of stay, is this not another type of elder abuse inflicted by the HMO industry? Are not such physicians who accept the financial incentives also guilty of abuse? Traditionally, financial elder abuse referred to "theft or conversion of money or other valuable by an elder's relative or caregivers."¹³ Cannot this definition be applied to Medicare HMOs and their contracted physicians who may shorten hospital lengths of stays and defer hospitalizing a patient in order to have a larger profit at year's end?

Advertisements in major newspapers aimed at the elderly encourage them to attend recruitment meetings; the ads are full-page size.¹⁴ However, the fine print explaining the details of the program often is difficult for the elderly, with visual impairments, to truly understand the "deal" being offered. Is this not a form of passive "cherry-picking" or "creaming" the healthier seniors? Evidence strongly suggests Medicare HMOs with at-risk contracts enroll healthier seniors than those who choose to remain in the fee-for-service sector.¹⁶ Frail elderly enrolled in a Medicare HMO were more than twice as likely to decline than those enrolled in a fee-for-service plan.¹⁶ Surely this cherry-picking also is elder abuse by the Medicare HMO industry.

How often do Medicare HMO recruiters go to assisted living settings, adult-medical/social day care, or residential health facilities? We have not yet been aware of such sessions. Could it be that the Medicare HMOs realize such patients often are the chronically

ill and infirmed, with only a small physiological reserve keeping them from permanent placement in a nursing facility? The Medicare HMO industry knows quite well the cost of care for such chronically ill elderly patients if enrolled would significantly drain their profits. Certainly this practice qualifies as passive elder abuse by the Medicare HMO industry.

An elderly patient enrolled in a Medicare HMO developed increasing confusion and agitation. When the family asked permission for a geriatric consultation, they were told a month wait would be necessary. When their Medicare HMO was asked if the primary care physician could see the patient "out of network," they were informed this was a completely noncovered service and would have to be paid in full by the enrollee.



Recently, Joyce Ramsey, a 69-year-old retired nurse in Riverside, California, was awarded \$1.1 million dollars in a binding arbitration with her Medicare HMO. Her primary physician requests for her referral to an HMO member kidney specialist were ignored or denied for two years. She subsequently required dialysis. The judge in the case called the HMOs conduct unconscionable.¹⁵ This withholding of necessary medical care is elder abuse/neglect

by failing to provide in a timely fashion necessary medical care.

Medicare HMO enrollees cite pharmacy benefits as one of the leading reasons for joining.¹⁶ Potential enrollees at recruitment meetings often are not told how physicians are urged to prescribe under an HMO plan. For example, PCS distributes to Medicare HMO contracted physicians, a small pocket-size prescription guide book.¹⁸ Within this booklet is a list of diseases and preferred drugs to prescribe. Each drug is listed in order of preference, using the number of dollar signs (\$ indicating the preferred drug, and \$\$\$\$ indicating the least preferred drug to prescribe). Nowhere can be found documented

literature supporting this prescribing policy. Surely, this is a form of elderly financial abuse as defined as the "use of deceptive business practices."¹³

The use of the infamous "gag-law" that forbade physicians from explaining to HMO enrollees the various options available to treat their particular disease is a flagrant violation of patient and physician rights and is a form of elder abuse, as defined by the withholding of vital information on the variety of treatment plans available.

The capitation strategy employed by Medicare HMOs is a form of elder abuse. By providing a fixed amount per patient per month, the contracted physician loses the incentive to see a patient for frequent followups.²⁰ This has the propensity for illnesses to be monitored less frequently and results in more serious conditions developing. Such pressures on the physicians force them to choose between the "best" test or treatment for their patients or a cheaper, second class approach.²¹ By using the definition of rationing to "any decrease in the quality of care intended to save money," elder neglect can be ascribed to this kind of Medicare HMO medical delivery model.

We strongly believe that there is a silent form of elder abuse being exercised, albeit legally, by the Medicare HMO industry. Health care providers as well as the government regulating bodies, must be aware of this type of subtle and occasionally obvious abuse of our state's senior citizens.

The authors are affiliated with MedWise Center, in West Long Branch, and with UMDNJ-School of Osteopathic Medicine, Center on Aging, in Stratford.

References

1. Price D: The ombudsman experience: Administrative protection for the vulnerable patients. *Trends, Health Care, Law Ethics* 8:49-56, 1993.
2. Conlin MM: Silent suffering: A case study of elder abuse and neglect. *J Am Geriatr Soc* 43:1303-1308, 1995.
3. Fulmer T, O'Malley TA: Inadequate care of the elderly: A health care perspective on abuse and neglect. New York, NY, Springer, 1987.
4. O'Malley HC, Segal J, Perez J: Elder abuse in Massachusetts: A survey of professionals and para-professionals. *Legal Research Services Elderly*, 1979.
5. Block MR, Sinnott JD: The battered elder syndrome: An exploratory study. University of Maryland Center on Aging, College Park, MD, 1979.
6. Hickey T, Douglas RL: Mistreatment of the elderly in the domestic setting. An exploratory study. *Am J Public Health* 71:500, 1981.
7. Lau E, Kosberg JI: Abuse of the elderly but informal care providers. *Aging* 229:5, 1979.
8. Wolf RS, Godkin MA, Pillemer KA: Elder abuse and neglect: Final report from three model projects. University Center on Aging, Worcester, MA, 1984.
9. Quinn MJ, Tomita S: *Elderly Abuse and Neglect*. New York, NY, Springer, 1986.
10. Group Health Association of America: Patterns in HMO enrollment. Washington, DC, Group Health Association of America, 1995.
11. Retchin SM, et al.: Outcomes of stroke patients in Medicare fee for service and managed care. *JAMA* 278:119-124, 1997.
12. Gross JS, Shua-Haim JR: Pheochromocytoma: On the verge of extinction under managed care. *NJ MED* 93:39-40, 1996.
13. Mewhinney K: Legal aspects of geriatric medicine, in Hazzard WR, et al., *Principles of Geriatric Medicine and Gerontology*. New York, NY, McGraw-Hill, 1994.
14. *Asbury Park Press*, September 9, 1997.
15. Freudenheim M: Pioneering state for managed care fights for change. *NY Times* July 14, 1997.
16. Reuben DB: Managed care: Good medicine for old people? *J Am Geriatr Soc* 45:643-644, 1997.
17. Shua-Haim JR, Gross JS: Study questions managed care's ability to care for frail seniors. *Elderly Health Serv Letter* 3:6.
18. PCS Clinical Formulary and Prescribing Guidelines, 1995-1996. PCS Health Systems, 1995.
19. Kelly C: When and how to get out of a managed care contract. *ACP Observer* Nov. 1996.
20. Prager LO: Capitation spurs doctor-driven utilization curbs. *AM News* January 15, 1996.
21. Kassier JP: Our endangered integrity—it can only get worse. *N Engl J Med* 336:1666-1667, 1997.
22. Asch DA, Ubel PA: Rationing by any other name. *N Engl J Med* 336:1668-1671, 1997.

Our prescription for health care news.

Medical Society of New Jersey

MSNJ

*Physicians dedicated to a
healthy New Jersey since 1766.*

TWO PRINCESS ROAD
LAWRENCEVILLE, NJ 08648-2302
609-896-1766
FAX: 609-896-1368

[HTTP://WWW.MSNJ.ORG](http://www.msnj.org)

☒ **SUBSTITUTION NOT PERMITTED**

**Your source for health care news.
<http://www.msnj.org>**

Mapping the brain in action

Eric J. Lerner

In the wake of the development of digital computers in the 1940s, medical researchers and electronic engineers drew analogies between computers and the brain, leading to the development of a dominant conceptual model of the brain as a computer, with neurons taking the place of transistors. For more than a generation, researchers focused mainly on trying to understand how billions of neurons communicating with each other individually through nerve discharges, as computer circuits do through electronic pulses, could perform the vastly complex tasks of the brain.

From the start, a minority of scientists pointed to the limitations of this model, particularly that it made the unitary functioning of the brain in perception and consciousness very difficult to understand: if the brain were a hundred billion cells functioning individually, how could perception and emotion involving a unified mind occur? But in the past decade, a new model of brain function has begun to evolve, one that emphasizes the cooperative, coherent action of large groups of neurons acting together as the basic mode of action of the brain. The rapidly

shifting levels of synchronization and desynchronization of the electrical activity of the brain at various frequencies and between various portions of the brain seem to be vital to the processes of perception and thought.

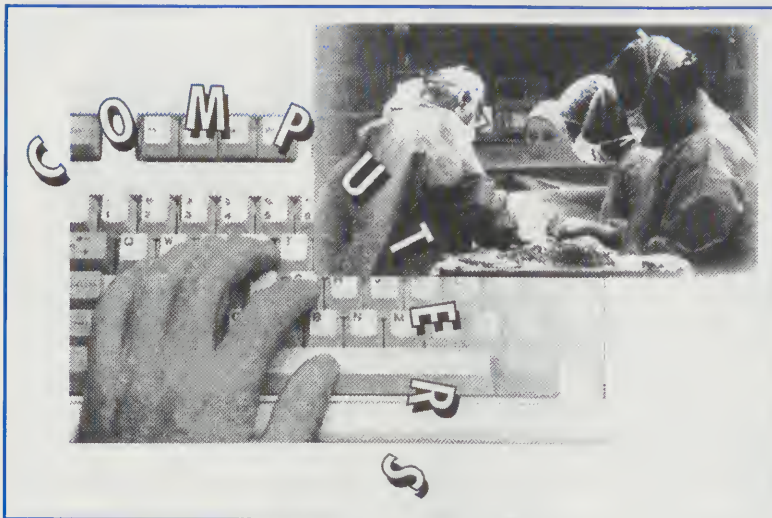
Perhaps ironically, this model has only gained substantial observational support as advances in computer technologies have allowed scientists to map the brain in detail while it functions. New computer techniques have made possible real time brain mapping in five dimensions; such time-frequency maps are giving greater insight into brain process and leading to the development of better noninvasive clinical tools.

The coherence of the brain. All of the new methods deal with the analysis of the electroencephalogram (EEG), the electrical fields generated by the brain, or the MEG, the magnetic brain waves. Early methods analyzed the EEG into frequency bands and studied the distribution of amplitude in the various bands or how this distribution varied depending on the position of electrodes. The new methods, made possible by far faster computers, study how the power in

various frequency bands varies in time, as well as over the surface of the skull. In addition, by using simplified models of how the brain produces the electrical currents, these methods make possible localizing the sources of certain EEG patterns in three dimensions.

One of the most sophisticated of the new brain mapping techniques is correlation mapping. In this method, EEG traces are taken from many electrodes simultaneously and a computer analyzes how often signals in a given frequency band are synchronized, or correlated, with signals in the same band in a different region. Such correlation maps, different for each frequency band, are sufficiently sensitive to distinguish between closely related conscious states.

For example, in work performed by Igor Hollander and colleagues at the Institute of Information Processing of the Austrian Academy of Sciences and at the Institute of Neurophysiology of the University of Vienna, correlation maps of a subject, who was a musician, were made at 6 frequency bands from 1.3 to 32 Hz using 19 electrodes. The subject performed various tasks such as reading a newspaper, reading a score, lis-



tening to text and to a Mozart quartet, memorizing the quartet, and doing mental arithmetic. The correlations were compared with the maps obtained when the subject was simply resting, and maps were created showing where correlations increased or decreased as well as where amplitude of the EEG decreased or increased from the resting state.

Remarkable differences in the patterns emerged. Correlations were much stronger at the highest frequencies while listening to text and at the lowest frequencies while listening to music. High-frequency correlations were even stronger when mentally listening to the music (memorizing it) but the pattern was quite different when reading the score. In certain maps, such as the highest frequency maps for listening to text and reading text, correlations were concentrated on one hemisphere. Researchers expect that by

studying large numbers of such maps with different activities and many subjects, underlying patterns will emerge that will begin to indicate how the brain performs higher cognitive tasks, and how information is communicated from one part of the brain to another by correlated electrical fields, not just individual neuronal pulses.

Clinical applications. The new techniques are finding application in clinical situations as well as in basic brain research. In particular, they provide a new invasive and very benign method of brain mapping and location of lesions for possible surgery. By making three-dimensional maps of the sources of EEG patterns, anomalous regions can be identified, often to an accuracy of millimeters. A dramatic example of this technique was in a recent study of victims of the Chernobyl nuclear accident, many of whom still suffer from brain disorders caused by irradi-

ation. Since the patients already have received very high doses of radiation, conventional mapping with computed tomography (CT) scans or positron emission both involving ionizing radiation, is clearly ruled out. But EEG coherence mapping could achieve considerable success in many of these patients without radiation or invasive methods.

Ludmilla Zhavoronkova and a team of physicians at the Institute of Higher Nervous Activity and Neurophysiology, Russian Academy of Science recorded paroxysmal EEG in several frequency bands with multiple electrodes and then modeled the results as if they originated with a simple dipole source (like a single charge oscillating back and forth in a straight line). They counted that in a given patient the model sources often were highly localized, at least for a given frequency band, in some patients, while rather diffuse in other patients. Patients with localized sources might be more likely candidates to benefit from surgery, and the localization in a specific damaged part of the brain also could guide medical management of the radiation-induced disorders.

Over time, EEG three-dimensional mapping may develop into a diagnostic tool comparable to CT and MRI scans of the brain, as well as providing perhaps the best window into the mysterious processes of thought.



**ALLEGHENY
UNIVERSITY OF
THE HEALTH SCIENCES**

Cardiology Update

Wednesday 3:00-5:00 p.m.

is designed for the health care provider and offers an intensive survey of the current status of clinical cardiology, allowing application of new knowledge and technology to the diagnosis and treatment of patients.

Program Directors: Bernard L. Segal, M.D. and Michael S. Feldman, M.D.

Wednesday, March 4

Geriatric Cardiology: What the Physician Should Know!

Moderator: Ami E. Iskandrian, M.D.

- **Clinical Manifestation of Heart Disease: Peculiar Drug Side Effects**
—Steven P. Kutalek, M.D.
- **Management of Lipid Disorders in the Geriatric Patient**
—David S. Poll, M.D.

Wednesday, April 1

Aggressive Intervention in Acute Cardiac Syndromes

Moderator: J. David Ogilby, M.D.

- **Primary Angioplasty vs. Thrombolytic Therapy: Relative Cost and Outcomes in Low and High Risk Patients with Acute Myocardial Infarction**
—J. David Ogilby, M.D.
- **Balloon Angioplasty vs. Stent Placement in an Acute Myocardial Infarction**
—Nelson M. Wolf, M.D.

Wednesday, May 6

Coronary Heart Disease: Newer Surgical Approaches

Moderator: Glenn Whitman, M.D.

- **Minimally Invasive Surgery: Uses, Limitations and Potential Liabilities**
—Clark Hargrove, M.D.
- **Transmyocardial Revascularization: Clinical Benefit or Vineberg Revisited?**
—James Sink, M.D.

at

Kaiser Auditorium

Allegheny University Hospitals, MCP
3300 Henry Avenue, Philadelphia, PA

CME Credits*

Call for Free Reservations: (215)-762-4137

Free Parking

Allegheny University of the Health Sciences, MCP♦Hahnemann School of Medicine is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education programs for physicians.

Allegheny University of the Health Sciences, MCP♦Hahnemann School of Medicine designates this educational activity for a maximum of 2.0 hours in category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in educational activity.

This program is eligible for 2.0 credit hours in Category 2A of the American Osteopathic Association.

calendar

FEBRUARY, MARCH, & APRIL '98

General Internal Medicine

February 17, 1998
UMDNJ, New Brunswick
732/235-7430

Interhospital Endocrine Rounds

March 4, 11, 18, and 25, 1998
University Hospital, Newark
973/982-6170

Society of Anesthesiologists

March 20-22, 1998
Trump Plaza Hotel & Casino
609/275-0083

Interhospital Endocrine Rounds

February 18 and 25, 1998
University Hospital, Newark
973/982-6170

Medical Grand Rounds

March 4, 11, 18, and 25, 1998
VA Medical Center, East Orange
973/982-6170

Academy of Otolaryngology

March 25, 1998
PNC Arts Center, Holmdel
AMNJ, 609/275-1911

Medical Grand Rounds

February 18 and 25, 1998
VA Medical Center, East Orange
973/982-6170

Head and Neck Oncology

March 11, 1998
The Manor, West Orange
AMNJ, 609/275-1911

Radiology Lecture

March 26, 1998
St. Barnabas Med Center, Livingston
973/533-5805

HIV Prevention Counseling

February 24-27, 1998
Location to be announced
609/984-6050

Vascular Society Mtg.

March 11, 1998
Cooper Hospital, Camden
AMNJ, 609/275-1911

Clinical Infectious Disease

March 27-29, 1998
The Plaza Hotel, New York
201/385-8080

Radiology Visiting Professor Lecture

February 26, 1998
St. Barnabas Medical Center, Livingston
973/533-5805

How Much Peritoneal Dialysis Is Enough?

March 17, 1998
Overlook Hospital, Summit
AMNJ, 609/275-1911

Urology Society Award Dinner

Spring 1998
Location to be announced
AMNJ, 609/275-1911

Diagnosis, Management, and Treatment of HIV

February 26, 1998
St. Joseph's Hospital & Medical Center
201/977-2113

Imaging of Primary Small Bowel Pathology

March 18, 1998
Cooper Hospital, Camden
609/342-2383

Endocrinology Visiting Professor Lecture

April 1, 1998
VA Medical Center, East Orange
973/676-1000 x1311

Oncology Society Clinical Abstract Meeting

March 3, 1998
The Manor, West Orange
AMNJ, 609/275-1911

Pregnant Women with HIV/AIDS

March 18, 1998
Union Hospital, Union
AMNJ, 609/275-1911

Interhospital Endocrine Rounds

April 1, 8, 15, 22, and 29, 1998
University Hospital, Newark
973/982-6170

Endocrinology Visiting Professor Lecture

March 4, 1998
VA Medical Center, East Orange
973/676-1000 x1311

Radiological Society Meeting

March 19, 1998
UMDNJ-RWJ Med School
973/533-5803

Medical Grand Rounds

April 1, 8, 15, 22, and 29, 1998
VA Medical Center, East Orange
973/982-6170

The Original

PHILADELPHIA
BOARD REVIEW
COURSE IN
CARDIOVASCULAR
DISEASESSM

Tuesday-Sunday
October 13-18, 1998

Sponsored Annually by



co-sponsored by
Council on Clinical Cardiology of the



Location: Wyndham Franklin Plaza Hotel
Philadelphia, PA

Why Should You Attend This Board Review Course!

- The Original Philadelphia Cardiovascular Board Review...offered since 1983
- Over 90% pass rate!
- *More days, more hours, more lectures, more topics than other courses*
- Geared exclusively for taking the Boards; contains all the required subjects, no research or esoteric topics
- Most Comprehensive Course Syllabus
- Fee includes continental breakfasts, luncheons, breaks, exhibits, and evening sessions
- Low hotel rates - close to great restaurants, shopping, theaters, museums, and sports venues
- Course faculty of nationally-known scholars

This program is designed to provide the physician with an intensive in-depth review of the clinical manifestations, pathophysiology, and treatment of cardiovascular diseases.

Allegheny University of the Health Sciences, MCP•Hahnemann School of Medicine is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

Allegheny University of the Health Sciences, MCP•Hahnemann School of Medicine designates this educational activity for a maximum of 50.0 hours in category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

This program is eligible for 50.0 credit hours in category 2A of the American Osteopathic Association.

All faculty participating in continuing medical education programs sponsored by Allegheny University of the Health Sciences, MCP•Hahnemann School of Medicine are expected to disclose to the audience any real or apparent conflict(s) of interest related to the content of their presentation.

Call 215-762-8264 for information or a brochure.



JOSEPH T. HAYES,

M.D., M.P.H., M.S.M., F.A.C.P.M.

**Associate—Specializing in Physician
Business and Financial Planning**

Licensed in Securities & Insurance

CALL FOR A FREE CONSULTATION AND BROCHURE

**732-831-0300 or
1-800-774-1734**

Focus Financial Group, Inc.

Registered Investment Advisor

P.O. Box 4516

Metuchen, New Jersey 08840-4516

**REGISTERED REPRESENTATIVE OF
CADARET, GRANT & CO.**

200 Valley Road, Mt. Arlington, NJ 07856

Member NASD/SIPC

**INTERNATIONAL COLLEGE OF
ACUPUNCTURE & ELECTRO-THERAPEUTICS**

*(Permanently Chartered by the University of the State of New York,
State Education Department)*

1998 Seminars & Workshops & 14th Int. Symposium

**ACUPUNCTURE & ELECTRO-THERAPEUTICS
in Clinical Practice**

25 credit hours can be earned by attending
one three-day weekend (Friday-Sunday) session **9 am-7 pm**

Feb. 13-15, 1998

Mar. 13-15, 1998 Holiday Inn, Manhattan

May 15-17, 1998 440 W. 57th St, NYC between 9 & 10 Ave.

June 19-21, 1998 Hotel 212-581-8100 during meetings

14th Annual International Symposium, Oct. 22-25, 1998

the School of Int'l Affairs, Columbia University

In addition to holding 7-8 seminars & workshops per year, the International College of Acupuncture & Electro-Therapeutics organizes an Annual International Symposium every October at the School of International Affairs, Columbia University, NYC and publishes **Acupuncture & Electro-Therapeutics Research**, **The International Journal** quarterly, through Cognizant Communications and is listed by 15 major international indexing periodicals (**Index Medicus**, **Current Content**, **Excerpta Medica**, etc.), is recognized as a major leading journal in the field. The most prestigious and internationally recognized, "Fellow of the International College" (F.I.C.A.E.) will be awarded to members of the College who present a minimum of 2 original research papers during the annual International Symposium and publish them in the official journal, or who have made significant contributions in the field.

These seminars & workshops train physicians and dentists in the latest theories and techniques of manual & electro-acupuncture, TENS & simple non-invasive diagnostic methods (including cardiovascular, neuro-muscular, central nervous systems & Bi-Digital O-Ring Test).

For information, contact Dr. Y. Omura, MD, ScD, FICAE, 800 Riverside Drive (8-I), NY, NY 10032; 212-781-6262, Fax 212-923-2279 or Dr. Richard Simon, PhD, 212-662-7022 or Ms. Sandra Beckman, MA, 212-679-8986. All ICAE meetings are accredited by the New York State Boards for Medicine and Dentistry toward the 300 accredited hour requirement for the Acupuncture Certificate in New York State. Also eligible for **AMA/CME Category I credit**. MSSNY designates this CME activity for **AMA/CME Category I credits** toward Physician Recognition Award.

APRIL '98/MAY '98

**Dermatological Society
Monthly Meeting**
April 14, 1998
Location to be announced
AMNJ, 609/275-1911

**Orthopaedic Society
Annual Meeting**
April 21-26, 1998
Palm Springs, CA
AMNJ, 609/275-1911

**Dermatological Society
Monthly Meeting**
May 12, 1998
Location to be announced
AMNJ, 609/275-1911

Pediatric HIV Infection
April 15, 1998
Union Hospital, Union
AMNJ, 609/275-1911

Pediatric HIV Infection
April 21, 1998
South Jersey Hospital, Elmer
AMNJ, 609/275-1911

Head and Neck Oncology
May 14, 1998
The Manor, West Orange
AMNJ, 609/275-1911

Pediatric HIV Infection
April 15, 1998
Warren Hospital, Phillipsburg
AMNJ, 609/275-1911

Radiology Lecture
April 23, 1998
St. Barnabas Med Center, Livingston
973/533-5803

General Internal Medicine
May 19, 1998
UMDNJ, New Brunswick
732/235-7430

**Potpourri of Interesting
Chest Cases**
April 15, 1998
Cooper Hospital, Camden
609/342-2383

**Medical Society of NJ
Annual Meeting**
April 28-May 2, 1998
Trump Taj Mahal Casino, Atlantic City
609/896-1766

**Pathology of Hemodialysis
Access Dysfunction**
May 19, 1998
Overlook Hospital, Summit
AMNJ, 609/275-1911

Radiology Society
April 16, 1998
Location to be announced
973/533-5822

Physician Health
April 29-May 2, 1998
Location to be announced
312/464-5073

Soc. of Anesthesiologists Mtg
May 19, 1998
Forsgate Country Club, Jamesburg
609/275-0083

**Radiological Society/Institute
of Ultrasound in Medicine**
April 16, 1998
St. Barnabas Medical Center, Livingston
973/533-5822

**Eastern Vascular
Society Meeting**
May 1-3 1998
Newport Marriott Hotel, Newport, RI
AMNJ, 609/275-1911

**Radiology
Society Meeting**
May 21, 1998
UMDNJ-RWJ Med School
732/235-7721

General Internal Medicine
April 21, 1998
UMDNJ, New Brunswick
732/235-7430

Interhospital Endocrine Rounds
May 6, 13, 20, and 27, 1998
University Hospital, Newark
973/982-6170

Opportunistic Infections
May 22, 1998
Newcomb Medical Center, Vineland
AMNJ, 609/275-1911

**New Clinical Trials
in Transplantation**
April 21, 1998
Overlook Hospital, Summit
AMNJ, 609/275-1911

**Endocrinology Visiting
Professor Lecture**
May 6, 1998
VA Medical Center, East Orange
973/676-1000 x1311

**Radiology Visiting
Professor Lecture**
May 28, 1998
St. Barnabas Med Center, Livingston
973/533-5803

HOUSING APPLICATION

232ND ANNUAL MEETING MEDICAL SOCIETY OF NEW JERSEY

APRIL 28-MAY 2, 1998

TRUMP TAJ MAHAL CASINO/RESORT

1000 BOARDWALK AT VIRGINIA AVENUE, ATLANTIC CITY, NJ 08401

RESERVATION DEPARTMENT 1-800-825-8888

(Please Print)

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Sharing With _____

Date of Arrival _____ Time _____

Date of Departure _____ Time _____

A one-night deposit (equivalent to room rate) is required with all reservation requests. Please send check or money order payable to the **TRUMP TAJ MAHAL CASINO/RESORT** or complete the following:

Card # _____ Type _____ Exp. Date _____

SCHEDULE OF RATES SUBJECT TO 12% TAX, PLUS \$2 PER ROOM, PER NIGHT

() SINGLE \$118.00 () DOUBLE \$118.00 EXTRA PERSON \$25.00

Reservations must be received prior to MARCH 30, 1998.

() One-Bedroom Suite \$275.00 per day () One-Bedroom Hospitality Suite \$350.00 per day

Check-out time is 12 Noon. Rooms may not be available for check-in until after 4 p.m. Check-in time on Sundays is 6 p.m. FORTY-EIGHT (48) HOURS NOTICE OF CANCELLATION is required for a full refund. PARKING: There is a state-imposed \$2.00 minimum charge per 24-hour period for each motor vehicle parking on the premises.

() Check if Official Delegate _____ County _____

PLEASE NOTE: Current state sales tax is 3% and occupancy tax is 9%, and room usage fee is \$2.00 per room, per night. These taxes are subject to change, without notice.

The proceeds from the fees collected shall be paid into a special fund which will be established and held by the Atlantic City Convention Center Authority. Amounts in the special fund shall be expended by the Convention Center Authority solely for the purposes of promoting tourism, conventions, resorts and casino gaming.

MAIL THIS APPLICATION TO: Reservations
Trump Taj Mahal Casino/Resort
1000 Boardwalk at Virginia Avenue
Atlantic City, NJ 08401

Housing Application online at www.msnj.org

THE MEDICAL SOCIETY OF NEW JERSEY CLASSIFIED ADVERTISEMENT INSERTION REQUEST

RATES

(Placement in New Jersey *MEDICINE* OR on WEB Site)

	<u>New Jersey <i>MEDICINE</i></u>	http://www.msnj.org <u>WEB Site</u>
Per Month—Non-Members		
Minimum 45 words	\$ 45.00	
plus each word		
over 45 words	\$ 1.00	
Per Month—Members		
Minimum 45 words	\$ 30.00	
plus each word		
over 45 words	\$ 1.00	
Per Month—		
Minimum 45 words		\$ 45.00
plus each word		
over 45 words		\$ 1.00

(Placement in New Jersey *MEDICINE* AND on WEB Site)

	<u>New Jersey <i>MEDICINE</i></u>	http://www.msnj.org <u>WEB Site</u>
Per Month—Non-Members		
Minimum 45 words	\$ 45.00	\$ 36.00
plus each word		
over 45 words	\$ 1.00	\$.80
Per Month—Members		
Minimum 45 words	\$ 30.00	\$ 36.00
plus each word		
over 45 words	\$ 1.00	\$.80

PREPARE YOUR COPY ON A SEPARATE PAGE AND ATTACH TO THIS ORDER FORM

INSERTION AUTHORIZATION

Name _____ MSNJ Member? Yes _____ No _____
 Company _____ Telephone Number _____
 Address _____ Fax Number _____
 City _____ State _____ ZIP _____
 New Jersey *MEDICINE* Issues _____
 Web # of 30 Day Insertions _____

New Jersey *MEDICINE*
 Non-Member
 Minimum 45 Words \$ _____ 45.00
 + Each Add'l Word @\$1.00 \$ _____
 Per Issue \$ _____
 X Number of Issues _____
 AMOUNT DUE \$ _____

MSNJ WEB SITE

Non-Member or Member
 Minimum 45 Words \$ _____ 45.00
 + Each Add'l Word @\$1.00 \$ _____
 Per Month \$ _____
 X Number of Months _____
 AMOUNT DUE \$ _____

New Jersey *MEDICINE*
 Member
 Minimum 45 Words \$ _____ 30.00
 + Each Add'l Word @\$1.00 \$ _____
 Per Issue \$ _____
 X Number of Issues _____
 AMOUNT DUE \$ _____

MSNJ WEB SITE WITH NEW JERSEY *Medicine* Placement

Non-Member or Member
 Minimum 45 Words \$ _____ 36.00
 + Each Add'l Word @\$.80 \$ _____
 Per Month \$ _____
 X Number of Months _____
 AMOUNT DUE \$ _____

TOTAL DUE \$ _____ ALL CLASSIFIED ADS MUST BE PRE-PAID

Please make check payable to "Medical Society of New Jersey"

Mail to: Classified Ad Department
 370 Morris Avenue
 Trenton, NJ 08611

Tel: 609-393-7196
 Fax: 609-393-3759

editorial guidelines

Editorial Guidelines

The principal aim in the preparation of a contribution should be relevance to health care and to the education of patients and health care professionals. The contents of each issue include an important health care development; an indepth interview highlighting a health care newsmaker; an update on a key public health issue; a peer-reviewed clinical report; brief highlights of the latest events and findings in the health care industry; and a monthly forum for readers. Proposals for special submissions will be considered on an individual basis. Letters to the editor are welcome and will be edited and published as space permits. Notices of events, programs, and meetings are encouraged.

Copyright

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or separate statement accompanying material offered to *New Jersey MEDICINE* must contain the following language, and must be signed by all authors.

"In consideration of *New Jersey MEDICINE* taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey in the event that such work is published in *New Jersey MEDICINE*."

Publication Policy

New Jersey MEDICINE will review original unpublished materials on topics relevant to health care professionals in New Jersey. All submissions are subject to peer review and are edited to conform to the style of *New Jersey MEDICINE*. Receipt of materials will be acknowledged. Final decision is reserved for the editor. No direct contact between the reviewers

and the authors will be permitted. Upon acceptance, authors will have the opportunity to review edited material. All communications should be sent to *New Jersey MEDICINE*, Two Princess Road, Lawrenceville NJ 08648.

Specifications

Materials compatible with Microsoft Word 6.0 for Windows should be submitted on diskette (3 1/2 inch), and should be accompanied by a printed copy of the material, a cover letter identifying the submission, and a copyright form.

The title page should include the full names, degrees, and affiliations of all authors, and the name and address of the author to whom correspondence should be sent.

The author(s) should submit a 30-word abstract to be used at the beginning of the article. References should not exceed 35 citations and should be cited consecutively by superscripted numbers at the end of the sentence. The style of *New Jersey MEDICINE* is that of *Index Medicus*: 1. Goldwyn RM: Subcutaneous mastectomy. *NJ MED* 74:1050-1052, 1977. Tables and graphs should be presented at the end of the article. Illustrations should be of professional quality, black and white glossy prints. The name of the author, figure number, and top of the figure should be clearly marked on the back of each illustration. When photographs of patients are used, the subjects should not be identifiable or publication permission signed by the subject or responsible person must be included. Materials taken from other publications must give credit to the original source. Generic names should be used with proprietary names indicated parenthetically with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol.



CLASSIFIED ADS

100 OPENINGS PHYSICIANS (MULTIPLE SPECIALTY LISTINGS)

THE PODELL MEDICAL CENTER

New Providence Holistic Health Center: Seeking collaboration from well-trained physicians from all specialties. Especially Women's Health: also Pediatricians or Family Physicians to help develop program for A.D.D. children. Contact Dr. Podell 908-464-3800 or fax 908-464-3078.

110 OPENINGS PHYSICIANS

BC/BE INTERNISTS— OCEAN COUNTY

Busy four physician multi-specialty group welcomes CVs from highly qualified BC/BE internists. Our newly renovated diagnostic lab and office is located in the Southern New Jersey shore area. We offer a competitive salary/benefit package and group-paid full coverage malpractice insurance. Please send CV to: Medical Associates of Ocean County, P.A., 53 Nautilus Drive, Suite F, Manahawkin, NJ 08050.

DERMATOLOGY PRACTICE OPEN OPPORTUNITY

Thriving well-established practice on Jersey Shore seeking energetic individual to assume practice. Can also accommodate P/T work, 1-2 days/wk; terms negotiable. Confidential Box #137, c/o NEW JERSEY MEDICINE, 370 Morris Avenue, Trenton, NJ 08611.

200 PRACTICE FOR SALE

ORTHOPAEDIC PRACTICE

Active Orthopaedic practice for sale—NE NJ (Suburban NYC Area)—in 1998. Differed financial incentives available for new Orthopaedist. Write: POB 4724, Clifton, NJ 07015.

300 OFFICE RENTALS AND LEASES

ATLANTIC CITY/ BRIGANTINE AREA

Medical Facility for Lease. Modern 6000 sq. ft., one story, walk-in medical center. Ample parking. Fully equipped physical therapy, lab, on-site x-ray and trauma center for non-life threatening emergencies. Large waiting room, business center and 12 exam rooms. Ideal for multi-specialist group, managed care and occupational medical facility. Additional equipment includes AT&T Merlin telephone system, file cabinets, EEG, EKG, defibrillators, whirlpool foot baths, electric exam tables, furnishings and more. A must-see facility. Long-term lease only. Possible city and casino contracts available. Atlantic City/Brigantine area. Call Mr. D'Annunzio 609-266-4000.

EDISON

Office Space—Edison Medi-Plex Building opposite J.F.K. Hosp. Fully equipped, turn key. Rent: day, half day, night. (732) 494-6300.

HILLSBORO

Hillsboro Medical Office—1,500 sq. ft. \$1,000/mo. Busy location. Active practices in building. Ideal for new or 2nd practice. Call Dr. Wolinsky 212-476-7789 days or 215-860-8491 eves.

MILLBURN

Medical Arts Building, Millburn Avenue. Fully equipped, turn key. Rent day, 1/2 day, night. Call 973-376-8670.

MOORESTOWN

Several offices available in Medical Complex. Various sizes. Excellent location. Stanley R. Lane, MD (609) 235-2651.

310 OFFICES TO SHARE

FORT LEE (BERGEN COUNTY)

Established 15 yr. Chiropractic Practice interested in sharing a 1600 Sq. Ft. space in modern office with 5 treatment rooms. Located in a residential area of Fort Lee—5 minutes G.W.B. Turnkey Operation. (201) 886-5151.

MARLBORO

Share medical office space with Internist. Family Practitioner in Marlboro on Full Prime location. Affluent area. Major shopping centers and many retirement communities closeby. Busy ENT next door. 2 exam rooms available. Abundant parking. Wheelchair accessible. Any Subspecialty welcome. Won't last! Call 617-8800.

325 MEDICAL BUILDING SALE OR LEASE

LAWRENCEVILLE

2300 sq. ft. Condominium Professional Building. Close to Rt. 1 corridor. Four exam rooms, consultation rooms. Large work areas. Full chair accessible bathroom. Two lab rooms. Lounge, storage space built-in. File cabinets. Private entrance in rear. Purchase or Lease. Daytime between 9:00 a.m. and 3:00 p.m. 609-896-0242.

340 REAL ESTATE HOME/OFFICE

MERCER COUNTY

Free standing office, approx. 2,000 sq. ft. exam rooms plus X-Ray room and Private Dr.'s office, waiting and reception. 2 acres professionally landscaped with parking. Fully equipped and ready for purchase. \$300,000 for this turnkey opportunity. 609-890-9009.

Offices are now available

at fully renovated

Medical Arts Building

230 West Jersey St. ELIZABETH, NJ

**Prime location near hospital and
public transportation, on site parking and more.**

Call for more information 908-354-3426

or Fax 908-351-4943

Are you a Hospital or Physician who wants a

PHYSICIAN ASSISTANT LET PA CONSULTANTS, INC. DO THE WORK

through our:

CONSULTATION PROGRAMS

Comprehensive review of state laws with an overview of the physician assistant profession

EDUCATIONAL PROGRAMS

Our inservice programs will educate all employees who come in contact with the new and exciting field

PLACEMENT

Our placement program will guarantee finding a qualified licensed candidate from our nationwide database

PA CONSULTANTS, INC.
357 HIGHWAY 9
SUITE 105
FREEHOLD, NJ 07728

PHONE: 732-683-1950
FAX: 732-683-1664

EMERGENCY PHYSICIANS

Emergency Physician Associates, a Team Health affiliate, is seeking quality ED physicians for a variety of practice opportunities in NJ, PA, MD, NC and NY.

We offer physicians competitive compensation, flexible schedules, malpractice insurance, a variety of practice settings, and supportive Medical Directors.

Interested candidates may call

1-800-848-EPA-1.



Specializing in the *Business of Health Care*

Physician Practice Assessment/Contract Negotiations/
Litigation Support/
New Practice Set-Up/Group Practice Formation/
Physician Income Distribution

RD HUNTER & COMPANY LLP

Certified Public Accountants and Consultants

Princeton Paramus New York City
Call us at 800-235-9381

Here's what we are covering in March 1998

How can physicians help patients make informed choices about parenthood?

MSNJ member Jane Brown Sofair, MD, offers physicians guidelines for helping patients consider the choices of remaining childfree versus having children.

What is the role New Jersey HealthDECISIONS?

Medical writer Bill Berlin interviews Richard Sinding, executive director of New Jersey HealthDECISIONS, and reveals the impact of this organization on residents in the Garden State.

What's new in diabetes research?

Writer Molly Davis talks with the top diabetes researchers in the state about the latest trends and developments.

What are MSNJ's guidelines for late-term abortion?

Based on its Expert Panel on Late-Term Abortion, the MSNJ Board of Trustees approved clinical protocols for late-term abortion.

How can the MIIX Healthcare Group help physicians maintain control?

President David Knowlton of the MIIX Healthcare Group discusses solutions to the dilemmas of practicing medicine in a managed care world.

How do magnetic fields offer hope in medical treatments?

Writer Eric J. Lerner reports on the latest uses of natural and artificial magnetic fields that affect the brain and its power, offering hope to victims of Parkinson's disease and MS.

Tune in for Mailstop, F.Y.I., Newsmakers, Editor's Desk, Online MSNJ, and Calendar.

Practicing medicine
= good

Practicing running
a business
≠ good

*Practice management and
practice efficiency solutions
from professionals with
hands-on experience*

WITHUM, SMITH & BROWN
Certified Public Accountants & Consultants
Health Services Department

100 Overlook Center
Princeton, NJ 08540

609-520-1188

<http://www.withum.com>

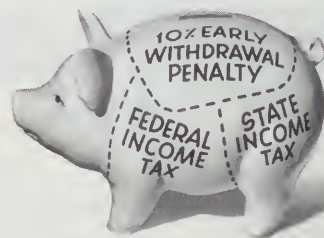
Offices in New Jersey and Pennsylvania



MEMBER NEXIA INTERNATIONAL
A WORLDWIDE NETWORK OF
INDEPENDENT ACCOUNTING FIRMS



Switching Jobs Can Have An
Unfortunate Effect On
Your Retirement Savings.



Don't Lose 40% Or More Of Your Retirement Plan To Taxes
And Penalties. Call For Your Free Information Kit Today.

T. Rowe Price can help.
Call for our free kit on
managing the payout from
your former employer's
retirement plan. The
kit clearly explains the
pros and cons of each

distribution option, so you
can decide what's best for
you. Because we'd hate
to see your retirement
plan go all to pieces.

1-800-541-4644

Invest With Confidence

T.RowePrice



Request a prospectus with more complete information, including management fees and other charges and expenses. Read it carefully before you invest or send money. T. Rowe Price Investment Services, Inc., Distributor. IRAR044



HEALTH LAW PRACTICE

*representing healthcare providers,
including physicians, physician groups, other
clinical professionals, academic medical
centers, multihospital systems, independent
acute care and specialty care hospitals,
ambulatory care centers, and nursing and
assisted living facilities*

For more information or a copy of our
New Jersey Health Law Advisory,
please contact
Alma L. Saravia
51 Haddonfield Road
Cherry Hill, NJ 08002 • (609) 488-7300

DUANE, MORRIS & HECKSCHER
A PENNSYLVANIA LIMITED LIABILITY PARTNERSHIP

Cherry Hill and Newark, New Jersey
with additional offices in
Pennsylvania • New York • Washington, D.C.
Delaware • Florida

continued from page 76

Membership dollars

From MSNJ president, Carl Restivo, Jr, MD: "MSNJ provides its members with some outstanding tools to make the practice of medicine easier for today's doctor."

Members have access to up-to-the-minute information about MSNJ and the changes in health care on MSNJ's web site (www.msnj.org). Each member has a home page on the site's Physician Finder. Legal counsel will

provide HMO contract review. Exclusively designed for members, the HMO Complaint Packet guides you through the maze of the HMO complaint and appeal process. Read about



Restivo, Jr, MD

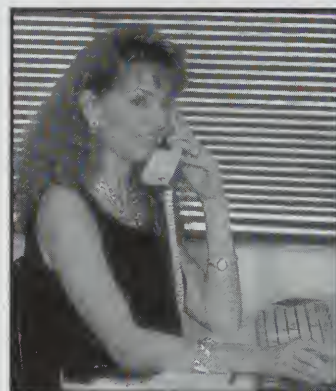
the forces changing the New Jersey medical environment in the award-winning magazine, *New Jersey MEDICINE*. Enjoy discounts and special plans on an array of products and services from our endorsed programs. Get easy, one-step accreditation with MRAC. International medical graduates can take advantages of the newly formed IMG Section. Tap into the Legal Consultant Network for legal advice and action. The membership directory and pocket calendar are mailed to all members.

Call MSNJ (609/896-1766) for information on MSNJ member benefits.



Can you hold, please?

While no doctor's office likes to put callers on hold, it can be necessary. Why not turn the time your callers are on hold into an informative experience? Enhance your telephone system's existing music-on-hold feature with a customized message-on-hold system. Message-on-hold programs consist of professionally narrated messages accompanied by music that play continuously through a telephone's music-on-hold feature. "The message-on-hold system is quickly finding its way into medical facilities and practices, because it's a cost-effective way to communicate with patients," says Neil Fishman, president of New Jersey-based HOLDCOM (1/800-666-6465).

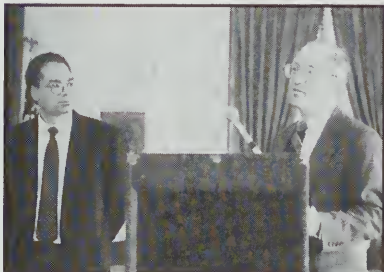


On-hold programs speak to callers one-on-one while they wait on hold, allowing a practice or medical facility to reduce caller hang-ups, answer frequently asked questions, and enhance the image of the practice. On-hold programs also can promote health care services and educate callers by providing useful health tips, medical updates, technical advances, and alerts to seasonal health concerns.

NJM

PUTTING OUT CIGARETTE SMOKE

Amid supporters of a tobacco tax increase, Governor Whitman signed the bill to raise the tobacco tax an extra 40 cents per pack, bringing the tax up to 80 cents. Many see the 40-cent tax as a win-win situation for New Jerseyans. "This is a big step toward the health of our children. This tax will discourage many children from starting to smoke.



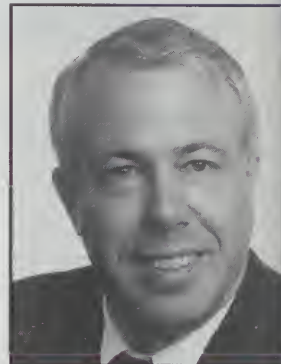
Larry Downs and Paul Wallner, DO

And the tax is in response to what the public wants," said Paul Wallner, DO, chair of New Jersey Breathes, the independent tobacco-control coalition convened by MSNJ. Under Project Director Larry Downs, New Jersey Breathes has been the driving force to put pressure on legislators to increase the tobacco tax.

With this tax increase comes a long-awaited feasible solution to charity care. Charity care, a top priority of MSNJ, comes as welcome relief for physician members and hospitals, many of whom have been shouldering the burden of charity care.

Vaccine tracking software

While most pediatric practice management systems offer some method to track immunizations as part of billing or medical records, for more comprehensive tracking doctors' offices turn to add-on software. MSNJ member and pediatrician Harris Lilienfeld, MD, put three add-on software packages to the test: PC Immunize 2000, Clinical Assessment Software Application, and Professional Immunization Manager. The results? The benefits of immunization tracking are clear.



Harris Lilienfeld, MD

Copies of Lilienfeld's review, "Tracking Immunizations," comparing the capabilities, strengths, and weakness of the three systems, are available for \$20 each from *Medical Software Reviews* Healthcare Computing Publications, 462 Second Street, Brooklyn NY 11215-2503, telephone 718/499-5910.

MSNJ delegation pushes for reform

Spurred on by the Sunbeam endorsement issue, the MSNJ delegation to the American Medical Association (AMA) flexed its muscle last year calling for structural reforms and a change in the AMA's leadership. Now, Irving P. Ratner, MD, is part of an AMA ad hoc committee investigating the AMA's handling of the Sunbeam matter. Ratner, first vice-president of MSNJ, was appointed to the ad hoc committee by the AMA's speaker of the House of Delegates. This appointment acknowledges the New Jersey delegation's influence at the AMA Interim Meeting in Dallas—and the events leading up to the meeting.



Irving P. Ratner, MD

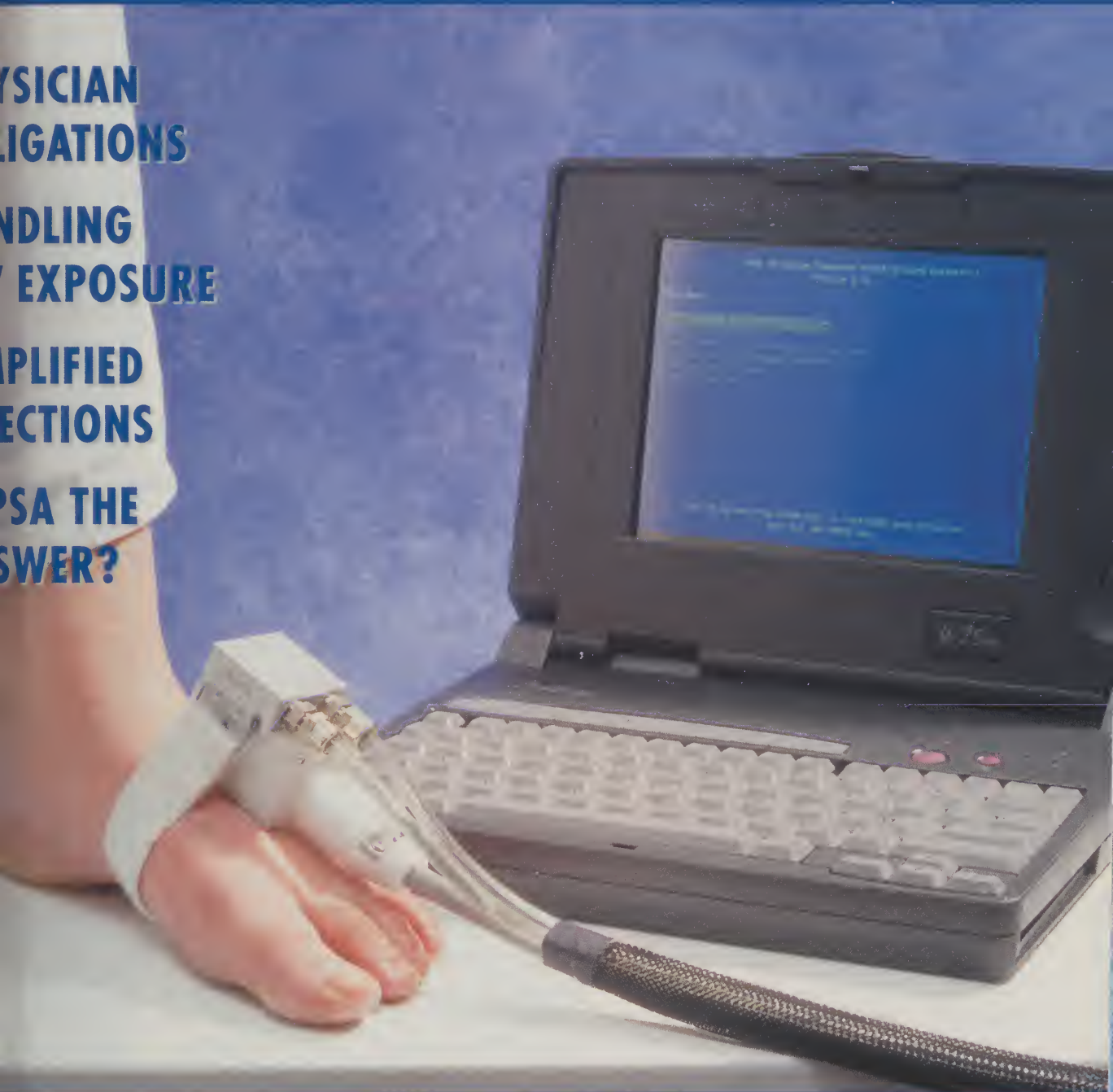
continued on page 73

New Jersey MEDICINE

Health Care in the Garden State

March 1998

PHYSICIAN
LITIGATIONS
HANDLING
EXPOSURE
AMPLIFIED
ECTIONS
PSA THE
SWER?



**The latest diabetes research:
Is the funding paying off?**

Y - O - U - R

PRACTICE

MADE MORE

PERFECT

WITH OVERHEAD EXPENSE INSURANCE FROM BLANKSTEEN

If you get sick, we'd like to help keep your practice well with overhead expense coverage that can reimburse office salaries, rent, insurance premiums, and utilities during an extended disability. Your needs are special, so call and talk with us. The only time to draw a blank in your insurance is when you fill it in with Blanksteen.



The _____ steen Companies

The Blanksteen Companies 253 Washington Street Jersey City, NJ 07302 201-333-4340 1-800-BLANK-AG
The Blanksteen Companies 161 William Street New York, NY 10038 212-732-9435 1-800-BLANK-AG
The **MEDICAL SOCIETY OF NEW JERSEY** endorsed plans, including Professional Overhead Expense underwritten by National Casualty Company.

JUL 13 1998

AUSTIN, TEXAS

New Jersey MEDICINE

newsWATCH

It's a baby step increasing the stride of New Jersey's tough new regulatory approach to managed care. With little fanfare, the Whitman administration has begun implementing a little noticed provision of the 1997 Health Care Quality Act that affects self-funded plans.

For the most part, these plans are regulated under the federal Employee Retirement Income Security Act (ERISA), which pre-empts most state regulation. But, the New Jersey law requires employers with self-funded health benefit plans to notify employees that their coverage lacks the protections of state law.

A compliance statement for ERISA plan employers was published in February in the state Department of Labor Employer Update.

Concept papers are due April 2 for the New Jersey Health Initiatives grant program. Public agencies and not-for-profit organizations are eligible for grants of \$50,000 to \$500,000. Contact the Health Research and Educational Trust of New Jersey at telephone 609/275-4128. Funding is supplied by The Robert Wood Johnson Foundation.

Physicians appear increasingly concerned about new documentation requirements for evaluation and management (E & M) codes. The Health Care Financing Administration has granted a six-month delay in implementation. The issue also has surfaced in New Jersey HMOs.

Some physicians complain that the new guidelines require inappropriately broad examinations of patients. The AMA is

struggling to seek a reasonable resolution.

Delays in HMOs' claims processing continue to confound physicians, hospitals, and state officials. Five months after an agreement between the Whitman administration and the New Jersey HMO Association (since renamed the New Jersey Association of Health Plans), the volume of complaints has not abated.

Originally, the plan was to extend the agreement, through regulations, to all HMOs, including those that are not members of the Association. But, efforts to implement or enforce the agreement have encountered problems of identifying responsible officials within HMOs, determining HMOs' compliance rates, and requiring frustrated providers to document individual instances of delay.

Other problems include defining "clean claims" that are subject to 10 percent interest penalties, confirming dates of receipt of claims, and assessing the accuracy of interest payments. An officer of MSNJ reports receiving an interest check of two cents.

However, another dimension of the issue is poor claims submission practices by physician offices.

Staff of MSNJ and of the New Jersey Hospital Association (NJHA) are considering a legislative remedy to the problems. For now, the administration is holding out for a regulatory approach. The difference is that legislation could prescribe higher interest rates, regular audits, tougher penalties, and other enforcement mechanisms.

New AMA research findings for 1996 confirm that younger physicians are far more likely to join group practices. Nationwide, 39 percent of physicians younger

than 36 years belonged to groups. The percentage drops steadily among successively older physician populations, to a floor of 20 percent of physicians 66 years and older.

In New Jersey, according to the AMA data, the average physician fees for an office visit with an established patient were \$70 (mean) and \$60 (median). For new patients the mean was \$122, and the median was \$100. The analysis excluded radiology, psychiatry, anesthesiology, and pathology.

Total professional expenses for self-employed New Jersey physicians were calculated at a mean average of \$218,000 and a median of \$131,000. Real income for non-federal physicians nationally fell 0.8 percent in 1996, says the AMA.

In 1997, New Jersey non-federal physicians obtained, on average, 29 percent of their revenue from Medicare and 8 percent from Medicaid. Private managed care contracts accounted for 38 percent of practice revenue.

Health and Senior Services Commissioner Len Fishman continues to seek a way to stifle complaints about certificates of need (CNs) for cardiac services. On February 13, the Health Care Administration Board gave overwhelming approval to a new Fishman proposal that had the general support of NJHA and MSNJ.

The proposal would allow two more hospitals to open cardiac surgery units, permit hospitals to expand cardiac surgery facilities more easily, and raise the number of procedures that cardiac surgeons and surgical teams perform

annually. Also approved was a demonstration project that would allow two hospital systems to combine an inner-city unit with a non-inner-city unit.

What are people buying with their health care dollars? Research innovations are being directed at benefit/cost trade-offs. As health care technologies improve and efficiencies grow, the benefits probably are increasing faster than the costs. Thus, health care "inflation"—such as a 3 percent annual rise in health expenditures—is not really inflation at all, but rather just a measure of how much people, firms, and agencies are choosing to spend on health care.

Managed care penetration into the small employer market has deepened, confirms the Center for Studying Health Systems Change. Earlier on, managed care was most popular among large employers. By 1966, says the Center, 25 percent of firms with fewer than ten employees, 28 percent of small employers overall, and 33 percent of large employers were contracting with HMOs.

After several months of deliberation and delay, the federal Health Care Financing Administration approved on February 13, a New Jersey waiver application on charity care. The waiver allows the state's new Charity Care Managed Care program to go forward without loss of federal dollars.

Devised by Mr. Fishman, the program requires hospitals, in order to qualify for charity care reimbursement, to include nonhospital-based services and substance abuse treatment in charity care programs. One aspect of the program is the new reliance on office-based physicians, who now will be part of reimbursed charity care networks. A small step toward a better system.

Neil E. Weisfeld

NJM

“LET US HAVE FAITH
THAT RIGHT MAKES
MIGHT, AND IN
THAT FAITH LET US
DARE TO DO OUR DUTY
AS WE UNDERSTAND IT.”



Abraham Lincoln, 1859

Setting rates is one of the most challenging tasks an insurer faces. At Princeton, we balance doctors' desire for low-cost professional liability insurance protection with the need to bring in sufficient funds to pay claims. Responsible rate setting, including savings for doctors with good claims experience, is in line with our longstanding commitment (one score and counting) to serve policyholders this century and beyond.

For a policy that delivers value in return for your hard-earned premium dollars (and cents), consult one of the independent agents who represent Princeton or call us at 1-800-433-0157.



Princeton Insurance Company

Professional Liability

Office Package Policy

Workers Compensation

Rated A- (Excellent) by A.M. Best Company 746 Alexander Road • Princeton, New Jersey 08540

REVIEW BOARD

Sofia Anthony, MD
 Paul W. Armstrong, Esq
 Richard M. Ball, MD
 Stanley S. Bergen, Jr, MD
 Harry M. Carnes, MD
 Gary S. Carter
 Elizabeth G. Christopherson
 Ellen M. Cosgrove, MD
 The Honorable Len Fishman
 Joseph E. Gonzalez, Jr
 Paul J. Hirsch, MD
 Ismail Kazem, MD
 Louis L. Keeler, MD
 Carol J. Kientz, RN
 James R. Knickman, PhD
 Paul R. Langevin, Jr
 George R. Laufenberg
 Martin S. Levine, DO
 Henry R. Liss, MD
 Gregg Lubinsky, RPh
 Ruth B. Mandel
 Michael R. McGarvey, MD
 Julane Miller
 Charles M. Moss, MD
 Patricia Murphy, PhD, RN
 Tom O'Neill
 Fred M. Palace, MD
 Mary Todd, DO
 William H. Tremayne
 F. Kevin Tylus
 The Honorable Charlotte Vandervalk
 Joan Verplanck
 Paul E. Wallner, DO

COUNCIL ON COMMUNICATIONS

Charles M. Moss, MD, Choir	Joseph W. Kozielski, MD
Harry M. Carnes, MD,	Clement H. Kreider, Jr, MD
Vice-Chair	Alan J. Lippman, MD
Henry R. Liss, MD, Vice-Chair	Robert M. MacMillan, MD
Richard M. Boll, MD	George J. Mellendick, MD, MPH
John P. Capelli, MD	Donald W. Orth, MD
Paul J. Corniol, MD	Robert M. Polloy, MD
Andrew B. Covit, MD	Sindy M. Poul, MD
Anthony Del Gaizo, MD	Arthur W. Perry, MD
Joseph A. DiLallo, MD	Nironjon V. Rao, MD
Michael J. Doyle, MD	Kelly M. Reid, MD
Leigh E. Ende, MD	Carl Restivo, Jr, MD
Steven C. Fiske, MD	John C. Riggs, MD
Jack Goldberg, MD	R. Gregory Sochs, MD
Daniel P. Greenfield, MD, MPH	John D. Slade, MD
George H. Hansen, MD	Leon G. Smith, MD
M. Arif Hoshmi, MD	Bessie M. Sullivan, MD
Christine E. Haycock, MD	Julie E.K. Timins, MD
Neil B. Horner, MD	Sandra S. Valdez, MD
Walter J. Kahn, MD	Poul E. Wallner, DO
Monroe S. Karetzky, MD	Richard A. Williams, MD
Ismail Kazem, MD	Angie Compo
Louis L. Keeler, MD	Eileen Martin Cohen
Scott P. Keil, MD	Anna Miranda

New Jersey MEDICINE

Health Care in the Garden State

EDITOR-IN-CHIEF
 Howard D. Slobodien, MD

EXECUTIVE EDITOR
 Geraldine R. Hutner, MA

ASSISTANT EDITOR
 Nancy M. Propsner, BA

ADVERTISING
 Cookson Media Services

PRODUCTION
 Trentypo, Inc.

PRESIDENT AND CHAIR
 Carl Restivo, Jr, MD

PRESIDENT-ELECT
 R. Gregory Sachs, MD

FIRST VICE-PRESIDENT
 Irving P. Ratner, MD

SECOND VICE-PRESIDENT
 Walter J. Kahn, MD

SECRETARY
 Bessie M. Sullivan, MD

TREASURER
 Eileen M. Moynihan, MD

IMMEDIATE PAST-PRESIDENT
 Anthony P. Caggiano, Jr, MD

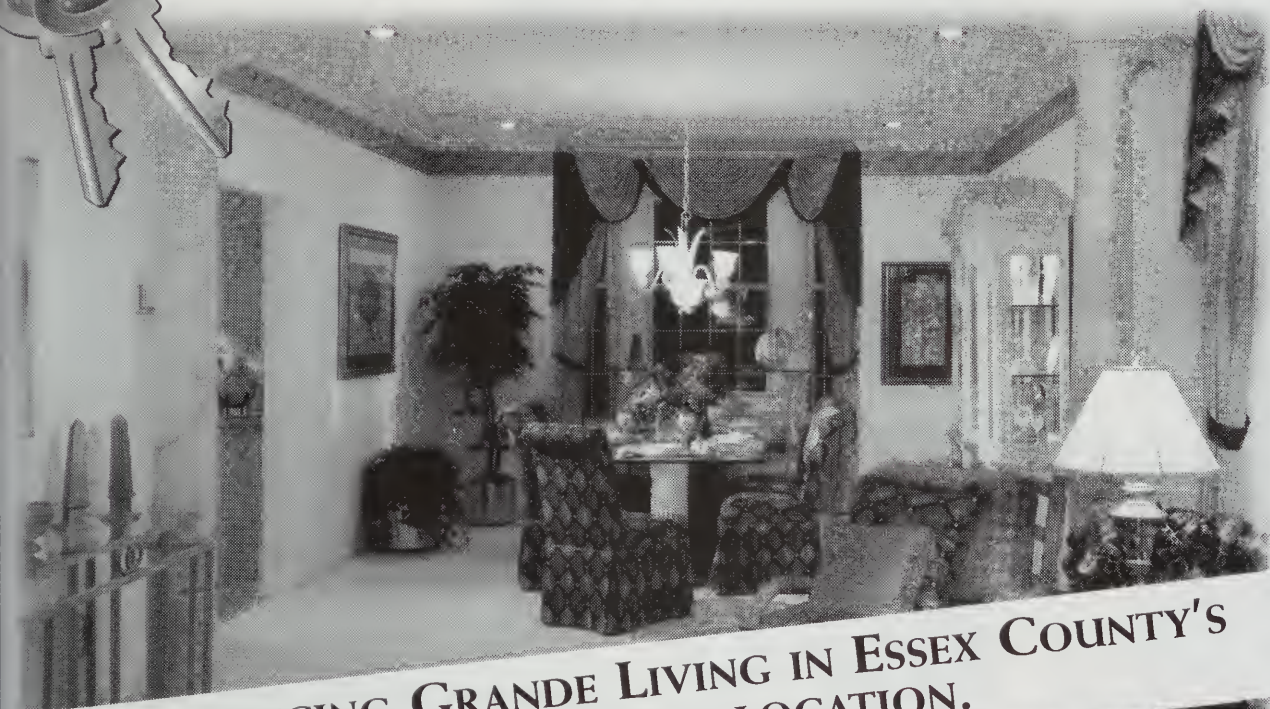
BOARD OF TRUSTEES
 S. Manzoor Abidi, MD
 Stevan Adler, MD
 Angelo S. Agro, MD
 Churchill L. Blakey, MD
 Donald J. Cinotti, MD
 Rajendra Prasad Gupta, MD
 David A. Ingis, MD
 Philip J. Jasper, MD
 Elliot M. Kraus, MD
 Giovanni Lima, MD
 Mark T. Olesnick, MD
 Robert S. Rigolosi, MD
 Michael J. Spedick, MD
 John W. Spurlock, MD
 J. Jerome Cohen, MD, OMSS
 Andrew Kunish, MD, Speaker of the House
 Susan Kahn, MSNJ Alliance
 John Y. Lee, Medical Student
 Daniel M. Greenwald, MD, Medical Specialty Societies

New Jersey MEDICINE (ISSN-088-5842-X) is published monthly (since 1904) under the direction of the Council on Communications by the Medical Society of New Jersey (MSNJ), Two Princess Road, Lawrenceville NJ 08648. Printed in Lancaster, PA, by Lancaster Press. Printed in USA. Whole number of issues 1125. Member's subscription (\$10) is included in MSNJ dues. Rates for nonmembers are \$50; outside of USA, add \$20. Single copy is \$7.50. Periodicals postage paid at Trenton, NJ, and Lancaster, PA. Copyright 1998 by MSNJ. March 1998. Internet address: <http://www.msnj.org>. E-mail address: info@MSNJ.org. 609/896-1766. FAX 609/896-1368. Postmaster: Send address changes to New Jersey MEDICINE, Two Princess Road, Lawrenceville NJ 08648. The appearance of advertising in New Jersey MEDICINE is not a MSNJ guarantee or endorsement of the product or service, by the advertiser. When MSNJ has endorsed a product or program, that will be expressly noted.

Medical Society of New Jersey
MSNJ



FEW HOMES CAN MAKE AS GRANDE A STATEMENT.



**INTRODUCING GRANDE LIVING IN ESSEX COUNTY'S
MOST BEAUTIFUL LOCATION.**

"Grande." The sound of it is undeniably regal. And certainly apt for homes as exquisite as those at The Grande at Pleasantdale. A simple stroll through one of our newly-opened models...a casual walk through our 50 acres of woodlands and you'll know for sure: this is one of the



The Grande
AT PLEASANTDALE

most prestigious communities in all of New Jersey. Elegance personified. SGS Communities continues its tradition of excellence with these spacious single-family homes of exceptional quality. To arrange a personal tour, please call 973-731-6111, or simply come by for a visit.

LUXURY ESTATE RESIDENCES PRICED FROM \$389,990.

SGS FEATURES HIGH QUALITY ANDERSEN WINDOWS AT THE GRANDE AT PLEASANTDALE
THE COTTAGE IS OPEN 10AM UNTIL 5PM SATURDAY THROUGH WEDNESDAY.



Directions: Take I-280 West to Exit 7, Pleasant Valley Way. Proceed right at bottom of ramp onto Pleasant Valley Way. At third light, make left at Eagle Rock Avenue. Proceed past the Pleasantdale Chateau entrance on your right to a right onto Oval Road. Make first right and follow the signs to The Cottage.



BROKERS WELCOME



CONTENTS

- 19** IN THE SPOTLIGHT
Interview with Richard Sinding
By Bill Berlin, PhD
- 23** HEALTH CARE FEATURE
Optional parenthood and the physician's role
By Jane Brown Sofair, MD
- 29** SPECIAL REPORT
Implementation of HIV postexposure prophylaxis guidelines
By Debra Bartelli, MPH, MA; Scott Moyer, MPH; Debra Mayer-Quezada, MD
- 37** CLINICAL REPORT
A simplified method of cesarean delivery
By Marco A. Pelosi, III, MD; Marco A. Pelosi, MD
- 49** PUBLIC HEALTH ADVANCES
Putting money where the disease is: Diabetes research
By Molly Davis
- 53** PUBLIC HEALTH ADVANCES
Prostate cancer: Is the PSA test the answer?
By Bill Berlin, PhD
- 57** FINANCIAL MATTERS
Are you entitled to a real property tax rebate?
By Robert J. Cirafesi, Esq; Michael F. Schaff, Esq
- 59** COMMENTARY
Helping physicians maintain control
By David L. Knowlton
- 67** POINT COUNTERPOINT
Physicians need to be members of organized medicine
By Joseph F. Fennelly, MD

NEWSWATCH 1

MAIL STOP 8

NEWSMAKERS 10

ONLINE MSNJ 12

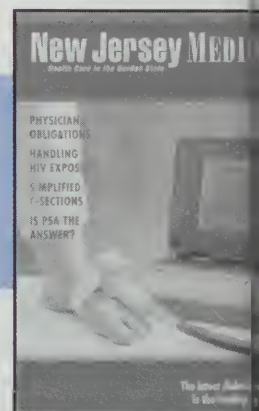
EDITOR'S DESK 15

MEMBERSHIP MATTERS 17

COMPUTERS IN MEDICINE 63

CALENDAR 70

F.Y.I. 80



The latest research with this diabetic neuropathy analysis—is being performed at Joslin Center for Diabetes at St. Barnabas, Princeton Division. Our report on diabetes research begins on page 49.

Cover: © Conrad Gl...

The best doctors and nurses.

ston, R.N., M.S.N.
President
Services

Luis A. Gonzalez, M.D.
Internal Medicine/Cardiology

Herbert Egbuna, M.D.
Pediatrics

John Hosay, Jr., M.D.
Urology

andez-Cos, M.D.
and Gynecology

Letitia Luna, M.D.
Cardiology

Doreen Lillo, R.N.P.A.
Department of Surgery

Right in your neighborhood.

Where do you find the best doctors and nurses in Hudson County? Our doctors are highly-skilled, caring professionals, many of whom are recognized experts in their fields. And every nurse is an R.N. That's why so many rate above the national average for providing excellent care.

Call (201) 418-2020.

**ST. FRANCIS
HOSPITAL**
of Jersey City

**ST. MARY
HOSPITAL**
of Hoboken



Franciscan Health System of New Jersey, Inc.

Member: Franciscan Health Partnership, Inc.

Curing cancer

Cancer is a genetic disease, and fundamental to its conquest is an understanding of the molecular biology that governs cell growth and replication. This knowledge, coupled with the ability to modify aberrant genetic mechanisms, promises to lead us away from purely empiric and often palliative treatments to definitive methods promising cure and real opportunities for primary prevention.

A new book, *Curing Cancer* (Simon and Schuster), provides an exciting story of genetic discovery, focusing on the leading scientists whose studies of cancer-causing genes have led to new insights already impacting on the practice of oncology.

The author, Michael Waldholz, (a resident of Montclair) is a Pulitzer prize-winning journalist and deputy editor for health and science at *The Wall Street Journal*.

Waldholz tells of Bert Vogelstein, the Johns Hopkins researcher whose Baltimore, Maryland, laboratory identified the growth-regulating p53 gene, a mutated form that allows uncontrolled cell division.

Later, the reader learns how pioneering work by Mary-Claire King at the University of California, Berkeley, provided the basis for believing that at least some

breast cancers are familial. And about Mark Skolnick, at the University of Utah, who is credited as the first to isolate the breast cancer genes, BRCA1 and BRCA2.

Based on these efforts, Waldholz explains, numerous biotechnology companies now are working fervently to identify genes responsible for many types of cancer and developing testing methods to identify individuals at risk.

Also considered in the book are the compelling ethical questions raised by this research—the circumstances under which such testing should be done, the problems associated with disclosure of sensitive genetic information, and the role of counseling and treatment programs for those genetically predisposed to cancer.

Genetic research carries immense implications for the future of cancer patient management. *Curing Cancer* provides a wonderful overview of

the complexities and the promise of genetic research.

Alan J. Lippman, MD

Testing pregnant patients

In his article "The importance of screening pregnant patients for AIDS" (*New Jersey MEDICINE*, December 1997) Joseph Appuzzio, MD, asks that pregnant patients be urged to accept HIV testing to protect their offspring, since perinatal treatment will significantly reduce the incidence of HIV transmission to the newborn.

Realistically, HIV testing should be mandatory. Anything less is called abuse of the worst sort. We jail people who knowingly transmit this virus, yet the state, by an act of omission, perpetuates transmission of HIV to newborns.

Charles Harris, MD

NJM

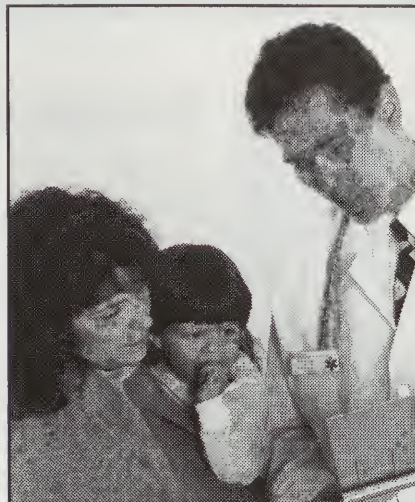
Requirements for letters

To submit a letter, FAX (609/896-1368), e-mail (info@MSNJ.org), or mail your letter to *New Jersey MEDICINE*, Two Princess Road, Lawrenceville NJ 08648. Letters should be typed and double-spaced and should be no longer than 400 words with up to 4 references, if necessary. Include your full name, affiliation, address, and telephone number.

Letters are published at the discretion of the editor-in-chief and are subject to editing and abridgment. Letters may be published on MSNJ's web site, <http://www.msnj.org>. Financial associations or other possible conflicts of interest must be disclosed. Letters represent the opinions of the authors.

what if[®]

you could choose a health plan that meets all your needs and fits your budget?



You can with the Medical Society of New Jersey's endorsed health carrier of choice. . .



**BlueCross BlueShield
of New Jersey**

If you're an individual or have a family to support, choose from:

- *HMO Blue[®]*
- *HMO Blue[®]* Prime
- Traditional Plans B, C and D
- Basic BlueSM (Plan A)
- And our new **M\$A BlueSM** plan with its tax advantages!

If you run a small business, choose from:

- *HMO Blue[®]*
- *HMO Blue[®]* Prime
- Blue SelectSM
- Blue Choice[®]
- Blue Choice[®] Prime
- Traditional Plans A, B, C, D, and E
- And our new **M\$A BlueSM** plan with tax advantages for employers and employees!

OR customize one plan for your company's specific business needs by combining as many as three of these plans. All offer attractive benefits. . . **All offer a 1-year rate guarantee upon enrollment!**



**BlueCross BlueShield
of New Jersey**



**INDIVIDUAL &
SMALL EMPLOYER
DIVISION**

Ask us for a free
copy of the SEH
Buyer's Guide.

Call your Blue Cross and Blue Shield of New Jersey

Medical Society of New Jersey
MSNJ

Sales Representative

JENNIFER ALTOBELLI

1-973-338-0893

® and SM Registered Marks and Service Marks of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans. Blue Cross and Blue Shield of New Jersey and HMO Blue are Independent Licensees of the Blue Cross and Blue Shield Association. HMO Blue is a subsidiary of Blue Cross and Blue Shield of New Jersey.



Karl T. Franzoni, MD

Spirit of St. Francis

Since 1955, MSNJ member **Karl T. Franzoni, MD**, has been affiliated with Trenton's St. Francis Medical Center. "Dr. Franzoni has played an important part in the lives of Trenton area citizens, bringing generations of families into the world," says Judith M. Perischilli, president and CEO at St. Francis Medical Center. In honor of his dedicated service, Franzoni has been awarded the 1997 Spirit of St. Francis Physician Award. At MSNJ, Franzoni has been a delegate to the House of Delegates and a member of the Committee on Revision of Constitution and Bylaws. He is a member of the Awards Committee and of the Mercer County Medical Society.



Leone N. Murphy, RN, MS, CS

Professional excellence

Leone N. Murphy, RN, MS, CS, was honored with The Arc of New Jersey's 1997 Health Care Professional of the Year Award. Her efforts have reached far beyond her goal of providing the best possible health and mental health services to patients with developmental disabilities at the Ambulatory Care Center. She designed the Center with a grant from The Robert Wood Johnson Foundation. The Ambulatory Care Center provides high-quality, cost-effective services for people with developmental disabilities. Three MSNJ member-physicians, John Nevins, DO, Catherine Schiano, DO, and Michelle Tomlinson, DO, provide physician services.

The new graduating class

The second annual commencement for the Medical Practice Manager (MPM) Program was held at the Rutgers University Continuing Education Center. The MPM program, sponsored by the Medical Society of New Jersey in cooperation with Rutgers University, is

designed to train medical office administrators in the latest management and computer techniques. Pictured are the graduating managers who received their certificates from MSNJ President Carl Restivo, Jr, MD (second from right, first row).



National honors for MSNJ members

Two MSNJ members, **Michael J. Gerardi, MD**, and **Julius A. Kaplan, MD**, were honored by the American College of Emergency Physicians (ACEP). Each year, ACEP honors national faculty who have been outstanding lecturers in the field of emergency medicine. Gerardi received an honorable



Michael J. Gerardi, MD

mention as outstanding national faculty of ACEP. The director of pediatric emergency services at Saint Barnabas Medical Center, Gerardi also is an attending physician in the Emergency Department at Saint Barnabas. Kaplan was awarded as the out-



Julius A. Kaplan, MD

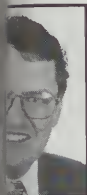
standing first year national faculty of ACEP. At Saint Barnabas, he serves as chair of the Department of Emergency Medicine, as first vice-president of the medical staff, and on the Board of Trustees. Both physicians are members of the Essex County Medical Society.

continued on page 11



continued from page 10

People in the news



P. Coyle

Joseph P. Coyle

has been named president and CEO of the Southern Ocean County Hospital.

The nationally recognized Lane W. Adams Award for oncology nursing has been awarded to **Peggy Joyce, RN**, an advanced practice nurse.

Paul A. Mertz has been appointed executive director of Newark Beth Israel Medical Center, an affiliate of the Saint Barnabas Health Care System.

Francis J. Cronin joins MLIIX Healthcare Group as vice-president of Consulting.



Francis J. Cronin

Elizabeth

Schaub-DeBlock has been appointed vice-president at Saint Barnabas Medical Center.



Elizabeth Schaub-DeBlock

Monmouth Medical Center perinatologist **David Wallace,**



David Wallace, MD

MD, has been elected president of the hospital's medical and dental staff. Also elected were MSNJ member Cary Glastein, MD, vice-president; MSNJ member R. Sivaprasad, MD, secretary; and Spiro Arbes, MD, treasurer.

Building healthier communities

The New Jersey Hospital Association (NJHA) is offering data that make the difference. NJHA demographic health profiles of all 21 counties will help community leaders assess their community's health and develop programs and services to meet their community's individual needs. **Building Healthy Communities: A Profile of the Community's Health** provides a snapshot of the health care landscape for each county. The easy-to-read profiles cover substance abuse, violence and crime, occupational and environmental hazards, and basic statistics on mortality rates and incidence of disease. "This is an invaluable tool for anyone interested in health improvement," notes Gary Carter, president, NJHA. For copies of the profiles, contact Penny Bolla, at NJHA, at 609/275-4157.



Gary S. Carter, FACHE

New naturalization requirements affect doctors

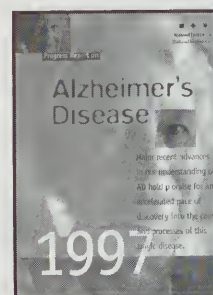
Based on new Immigration and Naturalization Service (INS) requirements that were published in the *Federal Register*, licensed medical doctors and licensed clinical psychologists must complete Part II of form N-648 Medical Certification for Disability Exceptions on behalf of individuals applying for citizenship whose physical or mental conditions prevent them from meeting the English and civics requirements for naturalization. These individuals must meet a "medically determinable" physical or mental impairment or combination of impairments that has lasted or is expected to last at least 12 months.

INS encourages doctors to make case-by-case determinations and to thoroughly complete Part II with specific descriptions of the medical condition and detailed information as to why the condition prevents learning or demonstrating use of ordinary English and the fundamentals of government and civics. For more information, contact INS at 202/514-5014 or www.ins.usdoj.gov/newsrels/pr.html.



Progress report on Alzheimer's

Get a copy of the National Institute on Aging's 1997 **Progress Report on Alzheimer's Disease**. It's available free of charge from the Alzheimer's Disease Education and Referral (ADEAR) Center. Contact Fran Gillen at ADEAR Center at 800/438-4380 or access the ADEAR Center web site at www.alzheimers.org/adear.



Evolution of a web site



© Double Exposure

Charles M. Moss, MD

MSNJ's web site (www.msnj.org) has exploded in the number of hits to its site—in just over a year. “Our site isn’t—and never will be—a stagnant site,” claims Charles M. Moss, MD, chair of the MSNJ Council on Communications. The key is change. Since its infancy, the site’s been constantly spruced up and modified to meet the always-changing demands of today’s Internet user. Monumental change is right around the corner, according to Moss. With the new user-friendly look and expanded features—scheduled for the spring—users will take a second look at www.msnj.org, promises Moss.

The web site’s claim to fame is its Physician Finder, an extensive database of MSNJ physicians and their offices. Patients can locate specialists in their area and access specific information about the doctor and practice. Likewise, doctors find the Physician Finder useful when making referrals. To sign up for your listing on the Physician Finder (MSNJ members only), call Margaret Fransckiewicz at MSNJ (telephone 609/896-1766) for an application.

Cookie crumbs

Not all cookies are bad. Some are actually helpful. So don’t get rid of all of them. The best programs designed to eradicate cookies allow the users to choose which cookies to cleanup. Try these programs for cookie control: Pretty Good Privacy’s Cookie.cutter (www.pgp.com), Junkbusters Corporation’s InternetJunkbuster 2.0 (www.junkbuster.com), and Kookaburra Software’s Cookie Pal (www.kburra.com).

Time on for good behavior

The recently published *Miss Manners’ Basic Training: Communication* gives us all a moment to pause about our behavior. The guru of social etiquette has incorporated the latest set of proper behavior in her new book. The first chapter covers “netiquette”: e-mail, Usenet, bulletin boards, and other Internet uses. If your mother didn’t teach you good manners, this book will.



Bookmarks

www.consumerreports.org

Don’t buy that big-ticket item without consulting *Consumer Reports* online with consumer advice, product recalls, and past issues of *Consumer Reports*.

www.njcommuntiy.org/hslanj

Librarians, check out the Health Sciences Library Association of New Jersey’s site.

www.jobspan.com/

Find one-stop job hunting from this online health care job-matching service.

www.nord-rdb.com/~orphan

Get info on rare disorders at the National Organization for Rare Disorders’ site.

www.njahp.org

Topics under the New Jersey Association of Health Plans’ site include: “Get Healthy,” “For Physicians,” and “Understanding a Health Plan.”



Practicing medicine
= good

Practicing running
a business
≠ good

*Practice management and
practice efficiency solutions
from professionals with
hands-on experience*

WITHUM, SMITH & BROWN
Certified Public Accountants & Consultants
Health Services Department

100 Overlook Center

Princeton, NJ 08540

609-520-1188

<http://www.withum.com>

Offices in New Jersey and Pennsylvania



MEMBER NEXIA INTERNATIONAL
A WORLDWIDE NETWORK OF
INDEPENDENT ACCOUNTING FIRMS



LET'S TALK!

NEED A BUSINESS LOAN?
CALL US FOR...

EXPERT HELP
FABULOUS SERVICE
COMPETITIVE RATES
FAST APPROVALS AND CLOSINGS

Loans up to approx. \$1,500,000 under the U.S. Small Business Administration Guaranteed Loan Program.

Approvals in 24 hours, or less.

Preferred (PLP) lender in New Jersey, New York and Pennsylvania.



Call 1-800-SBA-2005
ask for the "SBA Specialist"

PRESTIGE STATE BANK



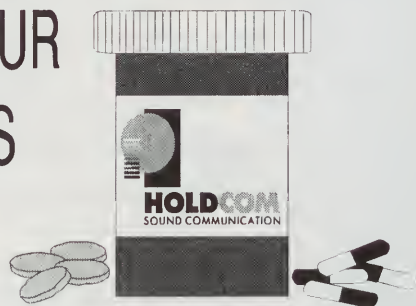
Equal Housing Lender Equal Opportunity Lender

Member FDIC

MAC



THE RIGHT PRESCRIPTION FOR YOUR CALLERS



Message-On-Hold Systems

Use your telephone music-on-hold feature to:

- ✓ Promote Services*
- ✓ Educate & Inform*
- ✓ Reassure Callers*
- ✓ Encourage Referrals*

HOLDCOM

Serving the NJ Healthcare Industry Since 1987

Call 1-800-666-6465

<http://www.holdcom.com>

Medical Society of New Jersey

Long Term Care Insurance Program

Ensuring a Secure Future by Preserving Assets

As medical professionals, you know first hand the devastating effects that extended long term care can have on a person's hard earned assets. The cost of nursing home stays can range from \$3,000-\$5,000 per month. The Medical Society of New Jersey endorses The Travelers and CNA Insurance Companies' policies to help you guard against unforeseen tragedies. Through a special arrangement with The Travelers and CNA Insurance Companies, members, spouses, parents and in-laws are eligible for a premium reduction.

IMPORTANT FEATURES OF THE MSNJ ENDORSED LONG TERM CARE INSURANCE PROGRAM

- ◆ Available Ages 45-84
- ◆ Specialty Plans Available Ages 80-100
- ◆ Benefits up to \$250/day
- ◆ No prior hospitalization required
- ◆ Several waiting periods
- ◆ Alzheimer's, senility covered
- ◆ Lifetime benefits available
- ◆ Guaranteed renewable for life
- ◆ Coverage for custodial, skilled and intermediate care as well as adult day care
- ◆ Available to your spouse, parents and in-laws
- ◆ Waiver of premium benefit
- ◆ Inflation protection available

DISCOUNT FOR MEMBERS OF MSNJ, SPOUSES, PARENTS AND IN-LAWS

For more information, please call

DONALD F. SMITH & ASSOCIATES

A division of THE COPELAND COMPANIES*

Two Tower Center, P.O. Box 1063
East Brunswick, New Jersey 08816-1063

(888) 297-7225

Copeland Associates, Inc.

Medical Society of
MSNJ

Are physicians agents of social change?

This was the subject of an interview with Victor Fuchs, the well-respected health care economist, in the January/February 1998 issue of *Health Affairs*. The session was reported by John K. Iglehart, long-time writer on health matters and familiar to readers of *The New England Journal of Medicine*. The answers deserve careful scrutiny; they offer insight into the past, present, and future of health care delivery.

Fuchs feels that public opinion will not support the policies needed to give the American people easy access to affordable medical care. As presently constituted, our system needs subsidies for those who are too poor or too sick, and it needs compulsion toward those able to afford coverage for care and unwilling to do so. But states that have tried to compel coverage have found insurers fleeing to other climes.

He also considers the most troubling trends to be: too much commercialization, erosion of professional norms, and the stampede to mergers and acquisitions. Fuchs thinks that having health care delivery run by business executives is frightening. "We risk losing sight of medical care as the expression of a professional ethic . . . there is a vast difference between a profit-making corporation and physicians who strive to balance their obligations to patients, the organization, and themselves."

If physicians want to regain some control, they must take a leading role in managing the delivery of health care for all Americans.

However, Fuchs found several positive trends to endorse, including the increased interest in setting priorities. He also praised the growing effort to shore up the scientific base of medicine. In this country we talk primarily of outcome studies to measure care. In other countries the emphasis is on evidence-based medicine.

The methodologies of the two systems are at opposite ends of the spectrum. Outcome studies do a retrospective examination of large groups of matched patients, and the analyses of the tests, treatments, and results then are used to recommend care for similarly afflicted individuals.

Evidence-based medicine enrolls patients in trials and analyzes the results of varying disciplines. It asks that physicians and other caregivers search the literature and other sources of scientific data in order to give validity to a course of action, rather than relying on "time-honored" methods that may be prolonging inferior care, and which some call opinion-based medicine. Sweden (with a state agency created in 1992), Britain, Canada, and other countries have established protocols based on evidence-based medicine. Several public and private agencies in the United States, including the Health Care Financing Administration and the Joint



Howard D. Slobodien, MD

No society has been able to abolish human sadness, no political system can deliver us from the pain of living. . . . It is the human condition that directs the social condition, not vice versa.

Eugène Ionesco, in the *London Observer*, 29 June 1958

Social improvement is attained more readily by a concern with the quality of results than with the priority of motives.

Eric Hoffer, *Reflections on the Human Condition*, 1973

Commission on Accreditation of Healthcare Organizations, also are attempting to form national policies that rely on this process.

Fuchs's understanding of professionalism, even if not *sui generis*, is persuasive. He feels the erosion of power in the medical profession is partially due to our inability, or our reluctance, to deal with the exploding costs of care. If we want to regain some control, we must take a leading role in managing the delivery of care. But, for us to be effective in accomplishing this, government must recognize the need and offer its assistance.

Physicians also must understand that professional standards represent only one type of social control and appreciate the three types delineated by economist Kenneth Boulding. The first, the exchange system, is how the market works. The second, the threat method, is the way government does it. The third is called integrative, and functions because of interpersonal relationships. The family, some types of schooling, and medical care at its best, are cited examples. The heterogeneity of medical care requires proper interplay between physician and patient, and neither the exchange nor the threat type of social control can suffice.

The section entitled, "On The Prospects For Reform," is especially evocative. Fuchs is pessimistic about the chances for comprehensive health care reform because Americans mistrust government; we are too much of a mosaic to feel kindly toward all segments of our population; and, unlike Europeans, we have a weak sense of *noblesse oblige*, the concept that magnanimity is an obligation of the more privileged toward those less blessed.

Although our cultural norms vary considerably from those in Europe, we still can learn from their experiences. Those countries also fear the rising costs of health care, but approach it differently. As noted above, they try to put care on a more scientific basis. Fuchs feels that, although "market" is a four-letter word" in capitalistic Germany and in other countries, the rate of growth of health care expenditures can be limited only from the supply side of the equation. He uses the term constraints. I would call it rationing—of facilities, caregivers, and technology.

Fuchs also discusses graduate medical education (GME), the role of the consumer, and the role of foundations. He thinks Medicare support of GME is inappropriate to its primary function. (I shall have more on this in a subsequent issue.) The consumer's role is subsumed by a large amount of ignorance, and is assumed by groups that may, or may not, represent the average citizen. He feels foundations are necessary to supplement and to monitor governmental efforts.

The more than 40 million uninsured, representing nearly 13 million (11.6 percent) of the 110 million families in the United States, face almost insurmountable barriers in obtaining coverage. Fuchs helps us to understand the problems and potential solutions. On several occasions, I have suggested a single payer-system as one answer to the problem of the uninsured, but the attitudes of many Americans, including physicians, as delineated in the section on prospects for reform, make me pessimistic, as is Fuchs, about comprehensive health care reform. Meanwhile, patients and their physicians continue to suffer.

MSNJ CLINICAL PROTOCOLS FOR LATE-TERM ABORTION

The following guidelines were approved by the Medical Society of New Jersey (MSNJ) Board of Trustees in December 1997.

MSNJ's Expert Panel on Late-term Abortion unanimously reaffirmed its June 19, 1997, *Report on Late-term Abortion* and its core commitment to the principle that physicians are best suited to promulgate clinical standards and that the physician-patient relationship affords the medically, legally, and ethically acceptable medium for the recognition, exercise, and protection of patient informed consent. The following guidelines are incorporated as an integral component of the *Report*.

I. MSNJ reaffirms existing policy that abortion is a medical procedure to be performed by a physician, in keeping with good medical practice, and that termination of early pregnancy remains a medical matter guided by patient informed consent and physician clinical judgment.

II. MSNJ reaffirms that the viability of the fetus and the time when viability is achieved varies with individual pregnan-

cy. In the second trimester, when viability is in question, the physician should determine fetal viability by using accepted diagnostic technologies.

III. MSNJ recommends, in keeping with the science and values of medicine as well as contemporary constitutional principles, that abortions not be performed beyond the point of fetal viability (currently defined as between 23 and 24 weeks of gestation) except in cases of serious fetal anomalies incompatible with life or extraordinary circumstances involving maternal health factors that demand termination of the pregnancy, and then only in a licensed facility acting in conformance with institutional policies and procedures and applicable regulations.

IV. MSNJ recommends the use of specially constituted late-term abortion ethics committees to afford patients and physicians the opportunity to identify the indications and contra-indications for such procedures, identify techniques that conform to the standards of good medical practice and ensure that decisions are patient-focused and properly evidence based. Ethics committee membership should include participation of, in addition to requisite medical specialties, a stan-

dard complement of multi-disciplinary membership.

V. MSNJ accepts the term "intact dilatation and extraction" (intact D&X) to refer to a specific procedure comprising the following elements: deliberate dilation of the cervix, usually over a sequence of days, instrumental or manual conversion of the fetus to a footling breach; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of the fetus to effect vaginal delivery of a dead but otherwise intact fetus. This procedure is distinct from dilation and evacuation (D&E) procedures more commonly used to induce abortion after the first trimester. Because "partial birth abortion" is not a medical term it will not be used by MSNJ or other medical authorities.

VI. MSNJ underscores that elective abortion procedures must be performed by a duly licensed physician and that reliable and confidential empirical reporting be made to the New Jersey Department of Health and Senior Services.

These guidelines endeavor to reflect the medical, legal, and ethical duty and responsibility of physicians concerning the life and health of maternal patients.

NJM

Lowest Premiums for Quality Malpractice Insurance

The Joseph A. Britton Agency can help make it happen. If you are a preferred risk¹, you can qualify for preferred rates². Compare these annual premiums at occurrence limits of \$1,000,000/\$3,000,000:

• <i>Anesthesiologists</i>	\$ 8,572	• <i>Radiologists</i>	\$ 5,331
• <i>General Surgeons</i>	\$18,453	• <i>Plastic Surgeons</i>	\$23,350
• <i>Internists</i>	\$ 5,331	• <i>Psychiatrists w/ect</i>	\$ 2,937
• <i>Ob-Gyns</i>	\$39,000	• <i>Urologists</i>	\$11,993

With more than 25 years of experience, the Britton Agency has proven exceptional in packing malpractice insurance. Our professional staff and size assure you the benefits of specialized, personalized service while offering you insurance at the lowest cost.

Call for a free consultation. Start saving tomorrow.



Joseph A. Britton Agency, Inc.

Healthcare & Professional Liability Insurance
855 Mountain Avenue, Mountainside, NJ 07092
(908)654-6464 • Fax: (908)654-1422 • 1(800)462-3401

¹Underwriting approval required. ²may need groups of 3 or more depending on specialty.



Druker, Rahl & Fein

Business Consultants
Certified Public Accountants

We have your prescription to profitability

We're Druker, Rahl and Fein, the accountants and advisors
to physicians and health care providers.

...Managed Care..Government Regulations

..the industry is changing..quickly.

How will these changes affect your practice?

You have questions and you need answers.

Our medical services experts will assist you
in developing a strategy to
succeed in this dynamic environment.

Leaders in:

Cost Accounting • Strategic Planning • Group Practice Formation • Tax
Managed Care Analysis • Practice Valuations • Practice Management

200 Canal Pointe Boulevard • Princeton, NJ 08540-5998 • 609-243-9700 • FAX 609-243-9799

Contact Robert J. Rahl, CPA

Bill Berlin, PhD

INTERVIEW WITH RICHARD SINDING

Mr. Sinding is executive director, New Jersey HealthDECISIONS, Inc., in Princeton.

Q: What is the mission of New Jersey HealthDECISIONS? Is it a successor to the Citizens' Committee on Biomedical Ethics?

A: New Jersey HealthDECISIONS has dual objectives. The first has to do with providing opportunities to and advocating on behalf of citizens to make their own personal health care decisions. The other is to provide a forum for direct citizen involvement in health care—participation in health care decision making and policymaking. On the one side, it is a very personal kind of thing, advancing patients' rights and giving citizens the empowerment to say this is what I want in the way of my health care. The second is to provide forums and opportunities for citizens to weigh in on health care policy.

Q: Much of health care decision making today is occurring at the level of insurance companies, large hospital chains, and managed care organizations. What is New Jersey HealthDECISIONS doing to get more citizen input into these organizations?



Richard Sinding

A: It's really a matter of getting information to the people who are making those decisions about what citizens want. A lot of the decision making and policymaking in health care is being done in the absence of citizen involvement, which is a widespread circumstance in today's society.

We are not presumptuous enough to think that we can pull the stakeholders together in one room and say, "Here's what citizens think." What we can do is survey what citizens think and what they want from health care, and then provide that information to policy-makers, decision makers, corporate purchasers, and providers of health care.

Q: Can you give an example of one area in which the organization has been active in this way?

A: We did a survey of how New Jerseyans want charity care to be funded. We released the results of that survey a few days after the gubernatorial election but before the start of the lame duck session where that issue was ultimately resolved. We found that there was overwhelming public support for increases in cigarette and alcohol taxes and that the least favorite options were the two that the state had used most recently—the tax on

© Armstrong Studios Ltd.

hospital bills or a raid of the unemployment insurance fund. To the best of my knowledge, there has been no other attempt made to quantify what the citizens of the state want in regard to health care. Now, I am not suggesting how charity care should be funded. I am not suggesting that every legislator ignore everything that the special interest groups are telling them and rush to do what the public is telling them to do. That's not what representative democracy is all about. But representative democracy should have the input of the citizens.

Q: Are you planning to do this with any other issues?

A: Actually, the charity care question was just a tip of the iceberg. It was part of a larger survey called the New Jersey Health Care Values Project, which seeks to quantify, compare, and contrast the relative importance that New Jerseyans attach to access, quality, cost, and choice in their health care. We also are looking at how people rate the performance of the New Jersey health care delivery system in each of these areas.

Our plan is to release the results of the survey, and

hopefully, to begin a dialogue about how to deal with this rapid change that is taking place in the delivery of health care. Here, at least, is an attempt to discern what citizens value in terms of the type of health care they receive, and the order of priority they attach to it. Also, there are some differences between northern and southern, urban and suburban, wealthy and not so wealthy, and males and females. There are a million ways to cross-reference the information that will be of use to policymakers, legislators, health care executives, and key people throughout the health care sector.

Q: Is this information enlightening for people like health benefits administrators?

A: We are planning a seminar for health benefits administrators and human resources administrators—the people who actually purchase health care plans on behalf of their employees. I don't know how many of them have actually surveyed employees about what kind of coverage they want. I suspect that most of this decision making is based

on the bottom line, which may not be the most important consideration for certain types of people under certain circumstances. Understanding what those circumstances are and knowing how that relates to the work force can help benefits administrators discover what their employees want.

Q: Do you think that most people believe the system is beyond their control, and that decisions are being made by large entities they cannot impact?

A: I'm not sure. Much of the frustration arises from the fact that the system has changed so dramatically and so quickly. Change by its nature draws this kind of frustration, particularly when citizens don't feel as though they have any influence over the change. One of the areas we tried to measure in our values survey was how important it was for respondents to be involved in planning and implementing health care policy. Interestingly, based upon preliminary analysis, the level of importance attached to that was considerably less than you might have expected. Essentially, many people

seemed to be saying, "For better or worse, I will trust people who know more about health care than I to make those decisions."

Q: What is New Jersey HealthDECISIONS doing to help people become better advocates for their health care?

A: One of our major goals has been to champion the autonomy of patients in respect to end-of-life decision making, and that debate, unfortunately, is not over. The debate over whether citizens have that right is over. However, the difficulties in terms of exercising those rights continue to be substantial. We need to get information about living wills and other advance directives into the hands of people in a timely fashion so that they can make decisions when they are competent about what should or should not be done if they become incompetent.

I'll use my own anecdote as an example. I went to a New Jersey hospital for preadmission tests to be admitted for open-heart surgery. After they asked a series of questions about my medical background, the question was asked to me, "You

don't have a living will, do you?"

Q: It was put negatively, almost like a kind of obligatory routine, like reading someone the Miranda rights?

A: That's exactly right, yet that's light years ahead of where we were before the passage of the Patient Self-determination Act or the New Jersey Health Care Directives Act. But the number of challenges also has increased manifold. It isn't just a matter of getting people to sign living wills or durable powers of attorney. We have been spending a lot of time lately dealing with the pressure to legalize physician-assisted suicide. All of these end-of-life decisions stem from the simple fact that people are seriously afraid of dying in pain. The Robert Wood Johnson SUPPORT study found that the overwhelming majority of people were, in fact, dying in pain, and that even if they expressed a wish to have life support ended, it was not being honored because physicians did not even know about it. We hosted the New Jersey SUPPORT summit to make the SUPPORT study well known to

leaders in New Jersey health care and interested citizens. We are devoting an entire day in our intensive bioethics conference to the issue of palliative care with nationally known speakers. We have a major grant proposal with the New Jersey Department of Health and Senior Services for a pilot program to train clinicians in long-term care facilities in the administration of palliative care.

Q: Have you ever thought of trying to get information into physicians' waiting rooms or hospital waiting rooms—places where people go for health care?

A: We are preparing a consumer's guide, *Patient's Rights in an Era of Managed Care*. The idea behind this is not patients' rights in managed care—that's a completely separate issue. But we're in an era of managed care, which has fundamentally changed the way many people receive health care. This is a reaffirmation of what basic patient rights are in the health care delivery system, and how those rights may or may not have been affected by the advent of managed care.

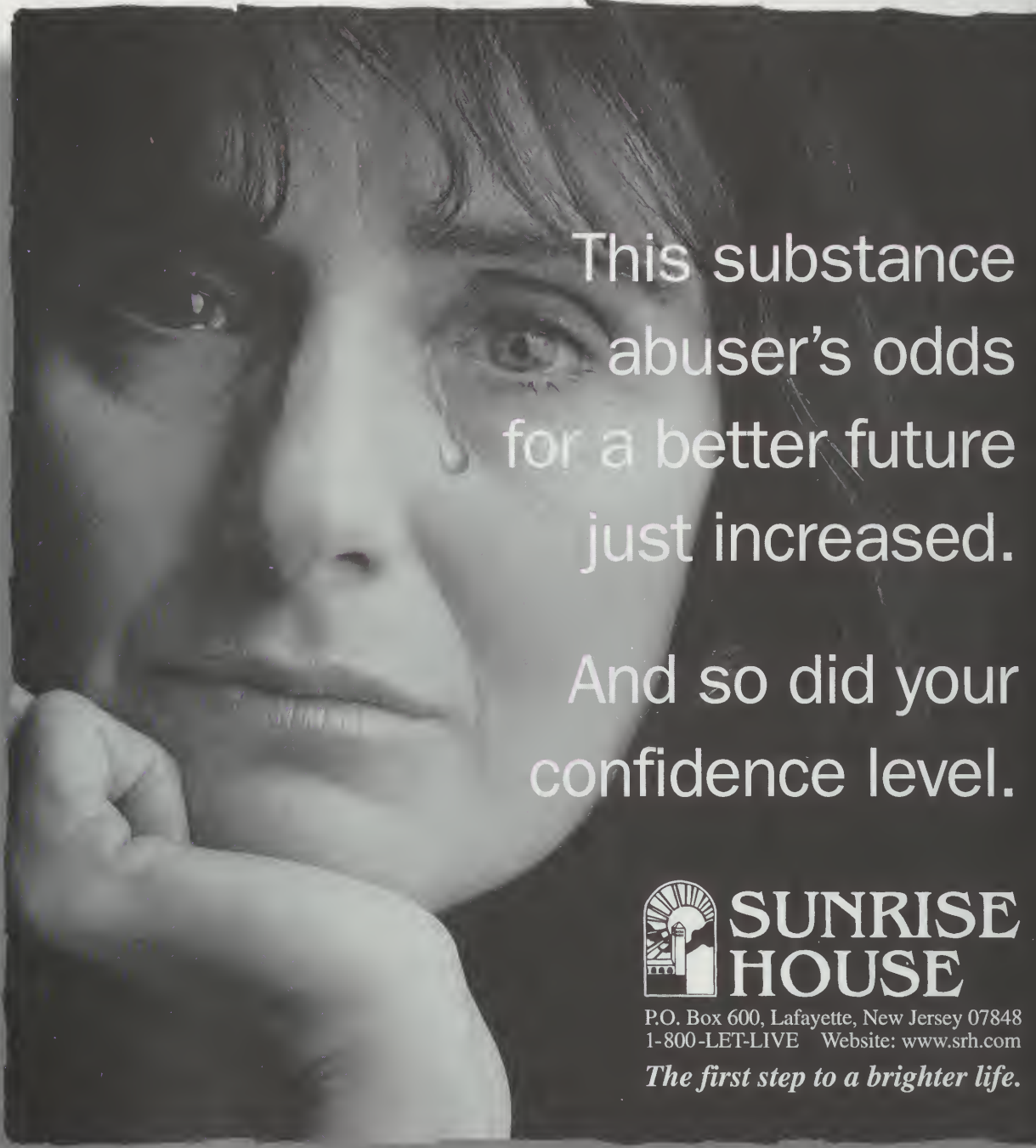
Whether it's an alcohol or drug problem, count on Sunrise House for expert help.

For 14 years, hundreds of tri-state area doctors have trusted us to offer their patients the most effective, caring treatment and a chance for a better life.

Set in the scenic hills of northwest New Jersey, we're a licensed, nonprofit specialty hospital with a nationally known commitment to quality—including Accreditation with Commendation by the JCAHO. Our comprehensive programs include inpatient and outpatient services, after-care and family support.

And our experienced staff of doctors and specialists works closely with referring physicians to ensure continuity of care at every stage of treatment.

Sunrise House. High-quality, affordable treatment you can trust. For information, call us at 1-800-LET-LIVE or (973) 383-6300.



This substance
abuser's odds
for a better future
just increased.

And so did your
confidence level.



**SUNRISE
HOUSE**

P.O. Box 600, Lafayette, New Jersey 07848
1-800-LET-LIVE Website: www.srh.com

The first step to a brighter life.

Sunrise House is a preferred provider of most major insurance companies and HMOs.
We will process insurance benefits verification and precertification.

Optional parenthood and the physician's role

Jane Brown Sofair, MD

How many physicians stop to ponder how they feel about parenthood during their normal working day?

Consider this case: Ann is a 25-year-old divorced, childless, nursery school teacher whose chief complaints are a sense of isolation and an apprehensiveness about her future. She is unfocused on whether to pursue an advanced degree or to devote her energy to "getting out there and meeting men." One day, she asks, "Why do people have children anyway?" I am a bit startled by the simple directness of this complex question and realize I cannot answer the question in a manner useful to her without examining my own biases.

As our therapy progresses, Ann is provided with a neutral forum in which she can explore these issues further, while I, as her physician, monitor where I stand on the pro-natalistic spectrum.

Eventually, Ann realizes that as a parent she does not want to re-create the dysfunctional family in which she has been raised, and would have to feel more

mature before making any decision about having a family. At the conclusion of her treatment, Ann is feeling more directed in life; she is actively socializing and deferring graduate school, but still quite undecided about parenthood.

Ann is a typical young professional seen by physicians, except that she is possibly going to remain childless by choice, thereby deviating from a deeply entrenched bias to be "fruitful and multiply." It is important for physicians not only to be aware of their own biases, but to educate themselves on the reasons that individuals might choose to remain childless.

From the late 1960s through the early 1980s, the nation examined the choice of voluntary childlessness as considered in such bestsellers as *The Baby Trap* and *Mother's Day Is Over*. This attention on childlessness reflected a number of well-known trends at the time: a push for gender equality, increased entry of women into the workforce, improved contraception, the delay of marriage and childbearing, the geographic disbursement

of the nuclear family, and changing norms as to what constituted the American family.¹⁻⁵

After the mid-1980s, the topic was put aside until recently when non-parenthood has been incorporated into a broader discussion of how gender consolidation plays a role in making life choices.⁶

Where are we today in our understanding of remaining without children? Clearly, the delay in having children still is very much in vogue, particularly among highly educated, professional women. The statistical likelihood of a woman in her late 30s or early 40s being without children now is about 18 percent.⁶ In 1990, 25 percent of all American women between the ages of 30 and 34 were estimated to be childless and it was predicted that 22 percent of women born between the years of 1956 and 1972 would be childless by choice.⁷ These rates are comparable to those between the two world wars, when childlessness among American women between ages 15 to 44 ranged from 16 to 24 percent.⁸

A working definition of voluntary childlessness is the deci-

Table 1. Sociodemographic predictors of voluntary childlessness.

Literature Source	Increasing Age	Advanced Education	Parents' Education	Religious Affiliation	Racial Origin	Marital Status	Residence	Employment Status	Income Status
Veevers	Yes, reaching end of reproductive capacity	College, plus		Low to none	Black/white differences unclear	Delayed first marriage, multiple marriages	Urban	Career-oriented	Affluent
Jacobson, Heaton and Taylor	Yes	Higher education	Advanced degrees for both; mother works out of home	Negligible effect without considering ethnicity	Native American high; Hispanic low	Single or common-law marriage	Urban, regional variation: West> North> South	In work force	
Pol		Higher education						In work force	Relatively high
Gustavus and Henley	Yes >41	College, plus		None		Married <6 years	Metropolitan Northeast	High status job	Relatively high
Callan	No, Early 20s	College, plus		Non-predictive		Single	University setting	Full-time students	

sion of an individual or couple to forego parenthood on either a biologic or adoptive basis. This decision is experienced as an exercised option rather than as a forced state, and the individual maintains an enduring commitment over time, although he or she might experience some degree of ambivalence.

Outwardly, voluntarily childless individuals present with characteristics similar to other upwardly mobile professionals. The childfree population is typically work-oriented, well-educated, urban, affluent, secular, and from backgrounds where the parents also were well-educated and achievement-oriented (Table 1).^{4,9}

Advancing age and higher divorce rate are additional markers of this population. In general, the older a childless individual becomes, the more likely he or she will opt to remain so. In fact, Veevers suggests that couples childless after five years of marriage tend to remain so in view of 90 percent of first births occurring during this particular time interval.^{3,4} Surveys of childfree intenders among university students leave open the possibility that their decisions will be altered over time and/or accidental pregnancies will occur. Callan, in an often-cited

work, found that of 102 university students averaging 23 years of age, 41 percent wished to remain childless, and of these, 70 percent had made their decision by the age of 18.¹⁰ Pol demonstrates a 30 percent reliability over a 5-year span among a group of women in their 20s committed to childlessness.¹¹

Houseknecht has found that childfree women come from achievement-oriented families with a matriarchal structure. The daughter simultaneously perceives that her mother is ambivalent about the maternal role, and that her father is predominantly work-focused; as she becomes a teenager, the daughter begins to distance herself psychologically from her family's lifestyle. She also strongly identifies with a peer reference group that supports her increasing sense of autonomy and validates her choice to remain childfree, should she ultimately choose this path.¹²

Gender development theorists postulate a critical distinction between reproductive awareness and reproductive choice. Notman and Nadelson emphasize a girl's early awareness of being able to have a baby as one of the central forces around which she organizes her identity, in contrast to a boy, whose

Table 2. Motivational pathways to voluntary childlessness.

Pohlman	1970	"Intentional Childlessness"	"Unintentional Childlessness" ± Adoption ± Marriage	<u>Emphasis:</u> —Ambivalence over time —Lack of rigorous empirically-derived definitions of different types of childlessness
Houseknecht	1974	"Early Articulators"	"Postponers"	<u>Emphasis:</u> —Family dynamics —Timing of the decision, early v. late in life —Autonomy and achievement orientation for both groups
Baum	1983	"Idealistic" "Emotional"	"Hedonistic" "Practical"	<u>Emphasis:</u> —Classification of married couples based on value system —"Emotional" and "idealistic" the most defensive in face of pronatalism —"Hedonistic" the most immune from pressures —"Practical" the most regretful and apt to feel most stigmatized
Callan	1984	"Early Articulators"	"Postponers"	<u>Emphasis:</u> —Deviance from traditional gender roles —Social stigma derived from pronatalistic pressures
Ireland	1993	"The Transformative Woman—Childfree"	"The Transitional Woman—Childfree and Childless"	<u>Emphasis:</u> —Childlessness as part of one's identity—based on choice —Childlessness in the broader context of gender-development

development appears to be less specifically interwoven with the specific issue of reproduction. The authors also mention a girl's early internalization of time constraints imposed on her fertility, also in contrast to a boy.¹³ On the other hand, the conscious decision of an adult to remain childless, in the vast majority of cases, is made in a vague, rather non-committal manner as time passes and circumstances unfold, rather than in a deliberate manner.¹⁴

Motivational factors for remaining childless are classified according to timing and to value system. Houseknecht's original model of "early articulators" versus "postponers" has endured over the past two decades and is quite similar to Ireland's more recent model of "traditional," "transitional," and "transformative" childless women. The articulators reject parenthood early on, and openly gravitate toward a non-traditional lifestyle, versus the postponers who hold more traditional values but cannot get their timing down (Table 2).^{4,6,14,15,16}

Baum has classified four styles of voluntarily childless couples. The "hedonistic" childless couple wants to preserve a free lifestyle. Such a couple does

not set out to be childless and cannot always pinpoint when they made the decision, but are basically comfortable with their choice and feel removed from pro-natalist pressures.

The "idealistic" couple is the most zealously committed to being childfree, usually for altruistic reasons. This couple discusses the decision carefully, considers adoption, but opts against parenthood. The idealistic couple loves children; they are apt to find ways of working with children either on a voluntary basis or professionally. They value their relationship together and are less traditional in gender roles than the hedonistic couple.

The "emotional" couple has an aversion to children. They value tranquillity and order in their lives and are likely to be judgmental about others' child-rearing practices. They also are apt to feel defensive about their decision, but not necessarily ambivalent.

Finally, the "practical" couple usually remains childless for a specific set of reasons, such as career or health issues. This couple feels unable to fulfill the parenting role satisfactorily, yet struggles with the

decision for many years. This couple is the most apt to feel regret in the later years, citing such factors as feeling lonely, missing important milestones, and fearing being regarded as self-centered. In the clinical setting, the physician almost always encounters an overlap in styles as illustrated by the following case which encompasses aspects of both the idealistic and practical couple.

Lisa, happily married for 10 years to a professor, was a 39-year-old, childless, college administrator pursuing an advanced degree. She entered treatment in a state of severe anxiety and depression seemingly correlated with a recent family holiday. She and her husband had for the past several years contemplated a pregnancy but never quite seemed to get around to it. She reported that she and her partner both felt that they could not measure up as parents due to the intense nature of their jobs coupled with the impossible standards they would place on themselves as parents. They based these feelings on knowing that they each tended to be perfectionistic in their endeavors. Lisa was one of five children and the only sibling in her family without offspring of her own. She tended to feel self-conscious in this regard. Her husband, in contrast, was an only child and felt no pressure from his parents to have children. Lisa was helped in treatment to feel more secure about her lifestyle which included remaining without children. Consequently, she was able to feel more comfortable in the presence of her family.

Turning to long-term adjustment, how does the child-free population cope with the aging process in comparison to the population with children? Veevers suggests that child-free persons enjoy lower rates of physical morbidity but higher rates of mortality than their parental counterparts. The author believes that being without children confers no adverse affects on emotional adjustment or the psychological well-being of older adults.³

Several studies have suggested higher rates of marital satisfaction among non-parenting than par-

enting couples.^{10,18} Increased emotional vulnerability among childless elderly women also has been observed. Alexander surveyed 90 female senior citizens without children and found a high incidence of regret in the areas of life fulfillment and generational continuity.¹⁹ Beckman and Houser found that childlessness had a greater negative impact on adjusting to widowhood among elderly women; widows without children reported more anxiety and loneliness than those with children.²⁰

What are the special considerations for health care professionals in working with the voluntarily childless in the primary care setting? First and foremost, the physician should be aware of his or her own attitude. In the words of Apfel and Mazor, "Reproduction is a subject about which everyone has strong feeling, beliefs, values, and fantasies; even more than in other areas of medicine . . . no one is neutral about reproduction."

Second, the physician should gently determine how the patient feels about being without children. For example, in taking a reproductive history, the physician might inquire, "What are your feelings about introducing children into your life at this point or in the future?" rather than, "Are you planning to have children?" Although the difference is subtle, the first question leaves room for dialogue whereas the second might make the patient feel defensive. If it is determined that the patient's childlessness is non-conflictual, the interview can move forward.

However, if not having children is creating discomfort for the patient, Rosenthal provides general guidelines for health care providers. Each provider should ask whether personal fulfillment is truly possible without procreating and what the "appropriate" versus "inappropriate" reasons are to have children. Through a variety of educational and cognitive techniques, the couple then is guided to the place that is comfortable for them at the moment, while being given permission to periodically re-evaluate their choice in the future. The couple should be asked to

st the pros and cons of childrearing. They should so practice role playing during a session to better deal with parents' questions and reactions.²²

Areas needing further attention include the development of standardized assessments of reproductive intention, a set of guidelines for physicians to identify and work with patients in turmoil on becoming a parent, and further exploration of the meaning of parenting and voluntary childlessness among men.

Dr. Sofair is affiliated with Morristown Memorial Hospital, and is a psychiatrist in private practice.

References

1. Beck E: *The Baby Trap*. New York, NY, Bernard Weiss Associates, 1971.
2. Radl S: *Mother's Day Is Over*. New York, NY, Varner Books, 1974.
3. Veevers JE: Voluntary childlessness: A review of issues and evidence. *Marriage & Family Rev* 2:2-6; 1979.
4. Jacobson CK, Heaton TB, Taylor KM: Childlessness among American women. *Soc Biol* 5:186-197, 1988.
5. Poston DL, Kramer BK: Voluntary and involuntary childlessness in the United States, 1955-1973. *Soc Biol* 30:290-306, 1983.
6. Ireland MS: *Reconceiving Women; Separating Motherhood from Female Identity*. New York, NY, Guilford Press, 1993.
7. May ET: Childfree: The revolt against the baby boom, in, *Barren in the Promised Land*. New York, NY, Basic Books, 1996.
8. Poston DL, Gotard E: Trends in childlessness in the United States, 1910-1975. *Soc Biol* 24:212-224, 1977.
9. Gustavus SO, Henley JR: Correlates of voluntary childlessness in a select population. *Soc Biol* 18:277-284, 1971.
10. Callan VJ: Single women, voluntary childlessness, and perceptions about life and marriage. *J Biosoc Sci* 18:479-487, 1986.
11. Pol LG: Childlessness: A panel study of expressed intentions and reported fertility. *Soc Biol* 30:318-327, 1983.
12. Houseknecht SK: Voluntary childlessness: A social psychological model. *Alternative Lifestyles* 1:379-402, 1978.
13. Notman MT, Nadelson CC: Changing views of femininity and childbearing. *J Clin Psych* 3:187-202, 1981.
14. Houseknecht SK: Timing of the decision to remain voluntarily childless: Evidence for continuous socialization. *Psych Women's Quar* 4:81-96, 1979.
15. Pohlman E: Childlessness, intentional and unintentional. *J Nerv Ment Dis* 151:2-12, 1970.
16. Callan VJ: Voluntary childlessness: Early articulator and postponing couples. *J Biosoc Sci* 16:501-509, 1984.
17. Baum FE: Orientation toward voluntary childlessness. *J Biosoc Sci* 15:153-164, 1983.
18. Renne KS: Childlessness, health, and marital satisfaction. *Soc Biol* 23:183-197, 1988.
19. Alexander BB, Rubenstein RL, Goodman M, Luborsky M: A path not taken: A cultural analysis of regrets and childlessness in the lives of older women. *Gerontologist* 32:618-626, 1992.
20. Beckman LJ, Houser BB: The consequences of childlessness on the social-psychological well being of older women. *J Gerontology* 37:243-250, 1982.
21. Apfel RJ, Mazor MM: Psychiatry and reproductive medicine, in, Kaplan and Sadock (ed), *Comprehensive Textbook of Psychiatry*. 5th Ed. Baltimore, MD, Williams & Wilkins, 1989.
22. Rosenthal T: Voluntary childlessness. *Am J Mater Child Nurs* 5:398-402, 1980.



All The Doctors...

Who Use Us For Accounts Management

**Found Us To Be Invaluable
in Safeguarding Their Income**

- *H.M.O. Claims Verified and Finalized*
- *Compensation and No-Fault Cases Settled*
- *Patient Balances and Self-Pay Accounts Collected*

Cut Office Costs

Eliminate:

- *In-House Collection Expense*
- *Your Office Staff's Endless Hours on the Phone with Insurance Companies*
- *The Constant Follow-Up With Patients That Promise to Pay Balances*

To Get More Information About Our Company Call:

Client Contact Company

1(800) 645-2303

E-mail: MedmanCo@AOL.com • FAX 1(800) 473-1184
2949 Long Beach Rd., Oceanside, N.Y. 11572



JOSEPH T. HAYES

M.D., M.P.H., M.S.M., F.A.C.P.M.

**Associate—Specializing In Physician
Business and Financial Planning**

Licensed in Securities & Insurance

CALL FOR A FREE CONSULTATION AND BROCHURE

**732-831-0300 or
1-800-774-1734**

Focus Financial Group, Inc.

Registered Investment Advisor

P.O. Box 4516

Metuchen, New Jersey 08840-4516

REGISTERED REPRESENTATIVE OF

CADARET, GRANT & CO.

200 Valley Road, Mt. Arlington, NJ 07856

Member NASD/SIPC

MEDICAL SOCIETY OF NEW JERSEY ALLIANCE

SAVE THE DATE

Saturday Evening

March 28th, 1998

NATIONAL DOCTORS' DAY GALA

to benefit the Physicians' Health Program

& AMA-ERF

PNC Reception Center

Holmdel, New Jersey

Exit 116 Garden State Parkway

Come to Honor & be Honored!

IMPLEMENTATION OF HIV POSTEXPOSURE PROPHYLAXIS GUIDELINES

*Debra Bartelli, MPH, MA
Scott Moyer, MPH
Debra Mayer-
Quezada, MD*

Ms. Bartelli is affiliated with the University of Medicine and Dentistry of New Jersey (UMDNJ). Mr. Moyer is affiliated with Mercer County HIV Consortium, in Trenton. Dr. Mayer-Quezada is associated with Metropolitan Hospital, in New York City.

The first documented case of HIV infection due to occupational exposure in 1984 led to the formulation of detailed recommendations and guidelines intended to ensure safe work practices in the health care setting.¹ In 1991, the Bloodborne Pathogens Standard legislation was adopted mandating safe work practices, now commonly known as universal precautions (UP). Yet, for a variety of reasons ranging from misperception of risk to ill-fitting protective wear to mechanical design of sharps,^{1,2} scores of hospital workers come in contact with potentially HIV-contaminated blood and blood products every day. Needlestick injuries, the most common route of

exposure, occur in hospitals at an estimated rate of 800,000 per year.²

Since 1981, the Centers for Disease Control (CDC) has conducted national surveillance to track the number of health care workers who became infected with HIV through such workplace exposures. As of 1996, CDC reported 52 documented cases of HIV infection attributable to the workplace setting; an additional 111 reports reflect possible occupationally acquired HIV infection.³

Current data indicate that percutaneous exposure poses the greatest risk to health care workers.^{4,7} A case control study conducted by the CDC identified four factors independently associated with risk of HIV infection after percutaneous exposure: deep injuries, visible blood on the device before injury, devices used in an artery or vein, and exposure to blood from a pre-terminal AIDS patient.⁷ Other occupational risks include blood or other blood-containing fluids coming into contact with mucous membranes, followed by skin contact. The average risk of infection from all types of parenteral exposure is estimated at 0.3 percent.⁸ The risk of infection for mucous membrane exposure is 0.1 percent.⁹

In the event that an occupational exposure to potentially HIV-infected blood or blood products occurs, protocols that permit the maximum benefit and minimum risk to the worker must be in place. Recognizing the importance of timely and appropriate management of workplace exposures, the U.S. Public Health Service convened a task force in 1990 to develop recommendations for postexposure prophylaxis (PEP).¹⁰ Because of the lack of sufficient, conclusive data about the benefits of prophylactic use of zidovudine (ZDV), these early guidelines did not make a recommendation either for or against the use of ZDV as a component of postexposure management.

Data from recent studies, which showed use of ZDV to result in a 79 percent reduction in the odds of HIV transmission along with the advent of ZDV-resistant strains of HIV, and the development of powerful new drug treatment options,¹¹ spurred the Public Health Service (PHS) to convene an interagency working group to review and update the existing PHS recommendations for management of occupational exposure to HIV. The revised recommendations, published provisionally June 7, 1996, continued to recommend the use of

Table 1. Sample characteristics.

	Eligible (%)	Participant (%)
Hospital Size		
≤349 beds	21 (37)	15 (33)
350-599 beds	31 (54)	26 (56)
≥600 beds	5 (9)	5 (11)
Total	57 (100)	46 (100)
Epicenter Status*		
Epicenter	29 (51)	25 (54)
Non-epicenter	28 (49)	21 (46)
Respondents	Eligible	Participant (%)
Infection Control	57	46 (81)
Emergency Services	31	11 (35)
Infectious Diseases	31	13 (42)
Occupational Health	—	3 —

*Determination of epicenter status was based on county cumulative AIDS cases.

ZDV but also added 3TC and Indinavir®, one of the new protease inhibitors.¹²

Our study set forth to determine the level of familiarity of New Jersey hospital infection control departments with the revised PEP guidelines and the extent to which the guidelines had been adopted in the state's acute care hospitals. We also were interested in determining whether a hospital's size or epicenter status influenced knowledge or adoption of the new guidelines. A third objective of the study was to determine whether the participating infection control departments had successfully communicated the elements of their PEP protocols

to other departments, namely infectious diseases and emergency services.

Methods. We contacted 36 of New Jersey's acute care general hospital infection control coordinators (ICCs) by telephone. The 36 directors represented all eligible hospitals of 350 beds or more listed in the 1995 *MSNJ Membership Directory*. In addition, one hospital per county with fewer than 350 beds was randomly selected for purposes of comparison, yielding a total sample size of 57. Pediatric hospitals, VA hospitals, as well as rehabilitation and psychiatric facilities were excluded. Secondary targets included directors of Departments of Infectious Diseases (ID)

and Emergency Services (ES) at those hospitals of 350 beds or more from which infection control directors had responded. Each received a mailed version of a questionnaire along with a self-addressed, stamped envelope. A followup mailing and telephone calls were used to increase the response rate. The survey was conducted between January and March 1997.

The questionnaire sought information about the participating hospitals' current PEP protocols, knowledge of the revised CDC guidelines, adoption of the revised guidelines, date of adoption, and methods of

implementing and disseminating information about the protocol. ICCs also were asked to submit a copy of their protocols for review.

Simple frequency analyses were used to summarize the data. T-tests were used, where appropriate, to test for differences by hospital size, epicenter status, and type of respondent.

Results. A total of 46 ICCs representing 81 percent of the eligible sample, agreed to participate by responding to a 18-item telephone survey (Table 1). Mailed questionnaires were returned by 13 (42 percent) of the eligible ID directors and 11 (35 percent) of the eligible ES

Table 2. Responses by size and epicenter status (% responding yes).

Questionnaire Item	Total N=46	Hospital Size			Epicenter Status	
		Small (15)	Medium (26)	Large (5)	Epicenter (25)	Non-epicenter (21)
Familiar with new PHS recommendations for HIV PEP?	98	100	96	100	96	100
Hospital have an HIV PEP protocol?	96	93	96	100	96	95
PEP protocol includes chemoprophylaxis?	96	93	96	100	96	95
Protocol includes ZDV, 3TC, IDV?	87	87	85	100	96	76*
Drugs on hospital's formulary?	72	60	81	60	64	81
Have a copy of the recommendations?	9	9	92	100	92	95
Postexposure counseling provided to injured employee?	100	100	100	100	100	100
Female employees assessed for pregnancy before administering PEP?	89	100	81	100	80	100
Hospital utilize needle-less system?	85	73**	92	80	84	86

*P=.02

**P<.03

directors. Three surveys originally mailed to ES directors were completed and returned by directors of occupational health. The low response rate from ID and ES directors partly is accounted for by the fact that in some hospitals, the ICC serves dual roles—functioning as director of both IC and ID. In other instances, hospitals originally included in the sample reported to have either no ES or no ID director.

Of the 46 ICCs who responded, 54 percent were from hospitals in epicenter counties. Nearly 57 percent of ICCs who agreed to participate were from hospitals with 350 to 599 beds. Similarly, 54 percent of the eligible sample represented hospitals of this size. ICCs from all five of the eligible hospitals with 600 beds or more agreed to participate. Finally, 71 percent of the eligible ICCs from the smallest hos-

pitals completed the telephone surveys.

We examined the overall aspects of participating hospitals' PEP protocols and we wanted to know if responses differed by epicenter status or by hospital size. Summaries are presented in narrative and tabular format (Tables 2 and 3).

Responses to the questions in Table 3 also were examined for agreement among the three respondent types to determine

Table 3. Responses to questions.**Are you familiar with the revised PHS guidelines for HIV PEP?**

Virtually all of the respondents answered positively to this question. Further, in followup probes to this question, 93 percent of the ICCs indicated they had the June 7, 1996, MMWR, the original source of information about the new guidelines for 85 percent of the respondents.

Does your hospital have a protocol for HIV postexposure prophylaxis?

Ninety-six percent of ICCs reported that their hospitals have an HIV PEP protocol in place. There were no significant differences either by epicenter status or hospital size although large hospitals were slightly more likely to have a protocol than were small or medium-sized hospitals.

Does your hospital's PEP protocol include chemoprophylaxis? If yes, which drugs are included?

Responses to these two questions, particularly the latter, provided answers to our main study question. If hospitals had adopted the new PHS recommendations, their responses should identify the three drugs (ZDV, 3TC, and Indinavir®) currently recommended under the new guidelines. In response to the first question, all but two ICCs reported using chemoprophylaxis. In response to the latter question, four (9 percent) reported using only one drug. Eighty-seven percent of the ICCs reported protocols that included all three recommended drugs and, therefore, appear to be in compliance with the new guidelines. Twenty-four of the 25 hospitals from epicenter counties reported using the three drugs, significantly more than non-epicenter hospitals ($P=.02$). No differences were detected when results were examined by hospital size. Overall, 96 percent of ICCs reported including ZDV, 87 percent included 3TC, and 85 percent included Indinavir® in their protocols. In response to a question about the date of adoption of the hospital's current HIV PEP protocol, more than one-half of those hospitals adhering to the new guidelines had adopted them between June 1996 and December 1996.

Are these drugs on your hospital's formulary?

An effective PEP protocol must ensure ready availability of and access to appropriate drug therapy for occupationally exposed workers. When a risk of HIV infection has been determined, antiretroviral prophylaxis should be initiated within one to two hours of exposure. One way for hospitals to ensure such access is to include the currently recommended drugs on their formulary. When asked, 72 percent of ICCs responded that the protocol drugs were on their hospital's formulary. Medium-sized hospitals were more likely than either small or large hospitals to carry the drugs on their formulary (85 versus 60 percent), however, the difference was not significant.

Is postexposure counseling provided to your hospital's employees after an incident?

All respondents reported that counseling is provided to potentially exposed workers at their hospitals. Components of this counseling were not explored as part of this study.

Are female employees assessed for pregnancy before initiating administration of PEP?

Eighty-nine percent of ICCs indicated that potentially exposed female workers are assessed for pregnancy before PEP is initiated. While all respondents from both large and small hospitals reported such assessments, only 81 percent of medium-sized hospitals responded positively to this question. Representatives of epicenter hospitals also were less likely than were their counterparts in non-epicenter sites to provide a positive response to this question. Although these findings were not significant, they do raise concern with regard to issues of fetal safety for female staff who may be pregnant.

Does your hospital utilize needle-less systems?

Eighty-five percent of infection control directors responded that their hospitals do utilize some form of a needle-less system for patient care. There was a significant difference ($P<.03$) between small and medium-sized hospitals in response to this question, with medium-sized hospitals more likely to report using needle-less systems. There were no significant differences when responses were compared by epicenter status.

whether communication about hospital HIV PEP protocols had occurred. Nearly one-half of the hospitals (46 percent) provided responses from two or more departments; responses from three target departments were received from 15 percent of the hospitals. For most questions, there was a high degree of agreement between the ICC's response and the corresponding ID and ES at their hospitals. However, three IDs and one ES reported that their hospital lacked a protocol for HIV PEP while the ICCs at their facilities maintained that such a protocol was indeed in place, indicating that adequate communication about the protocol had not taken place.

The survey also sought additional information regarding hospitals' PEP protocols. Questions were asked regarding the primary method of communicating information about the protocol, responsibility for administering postexposure treatment, and responsibility for following up the source patient. The latter question raised the greatest amount of disagreement with inconsistent responses from 43 percent of the hospitals.

A sample of hospital HIV PEP protocols was reviewed as a crosscheck evaluation of the extent to which the protocols incorporated the June 7, 1996, revised guidelines. While varying in length and complexity, all nine of the protocols addressed several essential components for the manage-

ment of potentially exposed health care workers. Only one hospital's protocol addressed all elements included in the CDC guidelines.

Appropriate timeframes for incident reporting and followup testing and treatment, a critical factor in the evaluation and medical management of the potentially exposed worker, were included in all nine protocols. Although all protocols noted that percutaneous, skin, or mucosal exposures must be reported, two protocols did not provide information about the level of risk for the various types of exposure nor did they make distinctions between the type of treatment recommended for each type of exposure. Detailed descriptions of the drugs used for PEP treatment and their respective side effects were included in three of the protocols.

Every protocol discussed the role of various departments in handling exposed workers, as well as the need to provide counseling. However, the content of such counseling, i.e. discussion of risks and benefits, particularly in cases of pregnant health care workers, was not consistently outlined nor was the importance of obtaining informed consent for testing and treatment.

The importance of reporting all potential exposures was universally stressed; however, only two protocols clearly stated that all reporting, testing, and treatments would be confidential.

As long as HIV infection remains a stigmatizing condition, assurances of confidentiality are essential to increase staff willingness to report incidents.

Discussion. The findings suggest that large hospitals and those from epicenter areas are slightly more likely to have adopted the new PHS guidelines for HIV postexposure prophylaxis. However, all but one ICC surveyed were familiar with the revised guidelines. Several ICCs indicated they were in the process of revising protocols.

Several study limitations are worth noting. In particular, the small sample size potentially masks real differences that may exist between hospitals of varying size and epicenter status. The inclusion of all hospitals of under 350 beds would have increased our sample size and, thereby, potentially increased our ability to make more reliable comparisons. As with any study that relies on self-reported data, the possibility of bias exists. It also may have been advisable to gather data about the incidence rate for occupational exposure at each of the hospitals surveyed, but given the small amount of variation among hospitals a comparison using such data would have been meaningless.

This study does not draw conclusions about the extent to which information about the revised guidelines has been disseminated to physicians, nurses, technicians, and other

health care staff of the hospitals surveyed. Further research is needed to assess whether adoption of the new guidelines has resulted in increased efforts to educate hospital personnel about the new guidelines. In addition, it would be important to determine whether the guidelines are being appropriately implemented and whether their adoption has made an impact on rates of reporting potential exposures.

Conclusion. This study indicates that New Jersey hospitals are aware of the latest PHS recommendations for HIV postexposure prophylaxis. Further, it shows that most have adopted these recommendations as part of their efforts to ensure appropriate, timely treatment, utilizing the latest therapies for staff exposed to HIV in the occupational setting.

As the group with primary responsibility for the adoption and dissemination of the revised guidelines, New Jersey hospital infection control directors appear to be well-informed and, on the whole, have successfully implemented the new protocol.

This study is important in that it demonstrates that New Jersey's acute care hospitals are in compliance with federal recommendations that affect the health of hospital workers. The study also highlights the need for effective communication between infection control departments and other key hos-

pital personnel. Clearly written protocols combined with staff training are integral in ensuring awareness of and adherence to guidelines that impact the possible long-term health of hospital personnel.

References

1. Gershon R: Facilitator report: Bloodborne pathogens exposure among health care workers. *Am J Indust Med* 29:418-420, 1995.

2. Fish D: Prophylaxis of HIV infection following occupational exposure. *Am Pharmacotheor* 27:1243-1256, 1993.

3. CDC: *HIV/AIDS Surveillance Report* 8:21, 1996.

4. McEvoy M, et al.: Prospective study of clinical, laboratory, and ancillary staff with accidental exposures to blood or body fluids from patients infected with HIV. *Br Med J* 294:1595-1597, 1987.

5. Gerberding JL, Littell C, Brown A, Raniero N: Cumulative risk of HIV and hepatitis B (HBV) among health care workers (HCW): Long-term serologic followup and gene amplification for latent HIV infection (abstract 959). *Abstracts, 30th Interscience Conference on Antimicrobial Agents and Chemotherapy* Oct. 21-24, 1990, Washington, DC.

6. Henderson DK, et al.: Risk for occupational transmission of human immunodeficiency virus type 1 (HIV-1) associat-

ed with clinical exposures: A prospective evaluation. *Ann Intern Med* 113:740-746, 1990.

7. CDC: Case-control study of HIV seroconversion in health care workers after percutaneous exposure to HIV-infected blood—France, United Kingdom, and United States, January 1988-August 1994. *MMWR* 44:929-933, 1995.

8. Tokars JL, et al.: Surveillance of HIV infection and zidovudine use among health care workers after occupational exposure to HIV-infected blood. *Ann Intern Med* 118:913-919, 1993.

9. Gerberding JL: Management of occupational exposures to bloodborne viruses. *N Engl J Med* 332:444-451, 1995.

10. CDC: Public Health Service statement on management of occupational exposure to human immunodeficiency virus (HIV), including considerations regarding zidovudine postexposure use. *MMWR* 39 (RR-1):1-14, 1990.

11. Gerberding JL: Prophylaxis for occupational exposure to HIV. *Ann Intern Med* 125:497-501, 1996.

12. CDC: Update: Provisional Public Health Service recommendations for chemoprophylaxis after occupational exposure to HIV. *MMWR* 45:468-472, 1996.

Critical Treatment for the Future of Your Practice...



Before It's Too Late

Wilentz, Goldman & Spitzer's Health Care Law Practice Group serves health care professionals regarding: group practice formation and operations; management service organizations (MSOs); physician practice management companies (PPMCs); managed care contracting; physician-hospital organizations (PHOs); independent physician associations (IPAs); restrictive covenants; and regulatory, employment, tax and litigation matters. **Think of us as preventive medicine for your practice.**

For information please call our Health Care Law Practice Group Co-Chairs: Michael F. Schaff at (732) 855-6047 or Francis V. Bonello at (732) 389-5636.

**WILENTZ
GOLDMAN
& SPITZER**
ATTORNEYS AT LAW

**"Helping The Health
Care Professional"**

Woodbridge, NJ
New York, NY
Eatontown, NJ

<http://www.newjerseylaw.com>

Subscribe to the award-winning

New Jersey MEDICINE

Health Care in the Garden State

Newswatch

Highlights of late-breaking findings and events

Mailstop

Monthly forum for readers and their opinions

Newsmakers

A who's who in the health care field

Editor's Desk

Thought-provoking comments from the editor-in-chief

In the Spotlight

Q & A with health care industry trendsetters

Health Care Feature

An important health care development

Clinical Report

Monthly peer-reviewed scientific investigation

Public Health Advances

Update on a key public health issue

Commentary

Special reports from Garden State leaders

Point Counterpoint

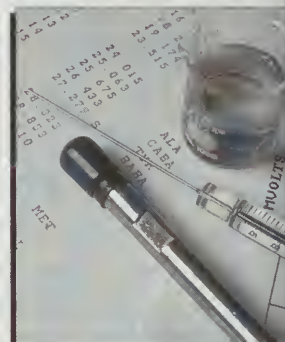
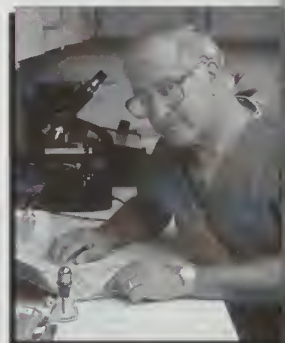
Differing views on a current controversy

Calendar

Schedule of important medical meetings

F.Y.I.

A who's who at the Medical Society of New Jersey



1 YEAR SUBSCRIPTION: \$50/12 ISS

Call today to order a subscription
1-800-322-MSNJ

NEW JERSEY MEDICINE - Health Care in the Garden State
TWO PRINCESS ROAD, LAWRENCEVILLE, NEW JERSEY 08648-2302

A SIMPLIFIED METHOD OF CESAREAN DELIVERY

Marco A. Pelosi, III, MD
Marco A. Pelosi, MD

The authors are affiliated with the Pelosi Women's Medical Center, in Bayonne, and with the Department of Obstetrics and Gynecology, Bayonne Hospital.

Common techniques of cesarean section in current usage utilize a transverse or midline abdominal incision, the mobilization of the bladder from the lower uterine segment, and a layered hysterotomy closure; these methods were introduced in the 1800s, long before the advent of antibiotics, reliable electrosurgical devices, modern anesthetics, and synthetic suture material. Although cesarean delivery, as commonly performed, is effective in exposing the uterus for fetal extraction, there are various steps in the procedure that are quite traumatic and others that are not essential to the goal of the operation but that contribute to a prolonged or morbid recovery by unnecessarily disrupting local tissue layers and organs.^{1,2}

We present a simplified technique of cesarean delivery, which has evolved through a

process of continuous modification and improvement on methods of traditional cesarean section, with the goal of reducing maternal morbidity and the convalescent impact of the postoperative recovery period. The preliminary experience was dramatic and illustrated the reproducibility of the operation.^{3,4} We report the results of our most recent 200 simplified cesarean sections.

Methods. From 1993 through 1997, 200 consecutive cesarean deliveries using the "Pelosi" technique were performed by the authors at Bayonne Hospital. Indications for cesarean delivery and relevant maternal data were recorded for all cases. Blood loss, in all cases, was estimated as the sum of the total volume of blood in the suction canister, in the collecting drape, and on laparotomy pads at the conclusion of the procedure. Operating time was obtained from the anesthesia record.

Postoperative febrile morbidity (greater than or equal to two temperature elevations in a 24-hour time period and greater than or equal to 38° C excluding the first 24 hours), ileus,

hemorrhage, wound infection, wound fascial dehiscence, and hematoma were considered as surgical morbidity. Analgesic intake and the time intervals to ambulation and to tolerance of a regular diet were noted from the nursing record for all patients. Following hospital discharge, all patients were evaluated in the office at 2 weeks, 6 weeks, and 12 weeks post-cesarean.

The surgical technique.

Patients are prepared with oral sodium citrate with citric acid (Bicitra®, 30 mL) given 30 minutes prior to surgery, suprapubic clipping (not shaving) of pubic hair, transurethral, indwelling bladder catheterization, and intravenous ampicillin sodium (Unasyn®, 3 g) after cord clamping. A superficial transverse skin incision is made with a scalpel 3 to 4 cm above the symphysis pubis. The subcutaneous tissue is incised transversely with the Bovie device in blend mode (combined cutting and coagulation current) to expose the rectus fascia (Figure A). The subcutaneous fat is not stripped widely from the fascia. Blood vessels overlying the fascia are desiccated in a brushing fashion



1
3

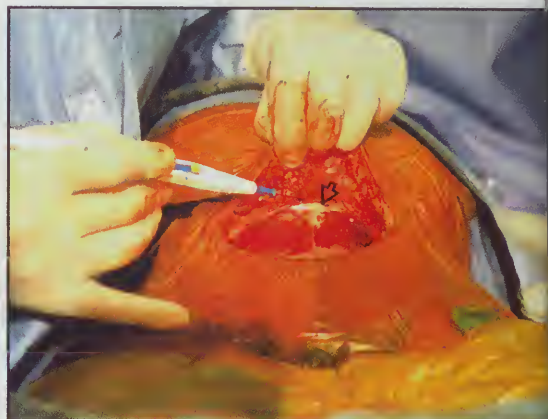
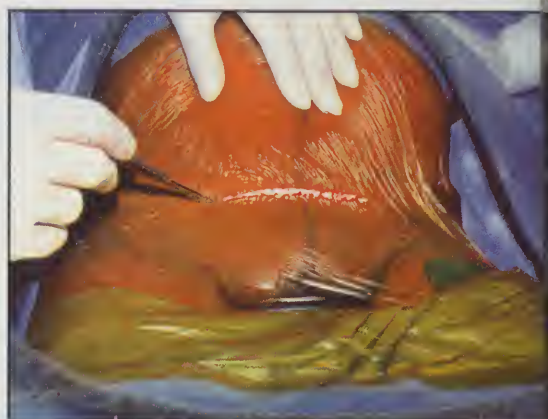


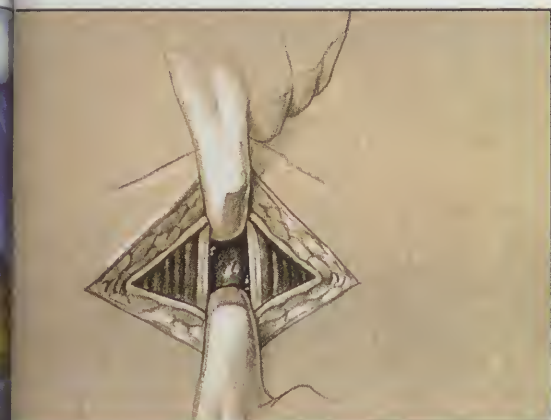
Figure A: 1 and 2. A transverse skin incision is made 3 cm above the symphysis pubis. 3. The subcutaneous tissue and rectus fascia are incised transversely with the electrocautery knife; the subcutaneous tissue is stripped widely from the fascia. 4. The linea alba (arrow) is identified; the rectus fascia is not stripped extensively from the rectus muscles.

prior to incision. The rectus fascia is incised transversely with the Bovie device; hemostats and clamps are not employed. Traction and countertraction are generated by hand. The upper (cranial) flap of the fascial incision is retracted cranially and separated from the linea alba for a distance of 2 to 3 cm, but is not undermined from the rectus muscles laterally (Figure A). The lower (inferior) fascial flap is not mobilized at all. The rectus muscles are separated in the midline by vertical (cephalocaudal) traction with the fingers to expose the peritoneum or sharply when scarring is present. The peritoneum is opened with the finger (Figure B) or sharply (Figure C) if this layer is scarred. Any adhesions in the operative field are lysed. The full thickness of the abdominal wall inci-

sion then is gently stretched to the limits of the incision bilaterally (Figure C). The peritoneal incision is extended bilaterally, if necessary.

The bladder is retracted caudally by a Balfour retractor and the uterovesical peritoneal reflection is retracted caudally by the assistant. A 1 cm uterine incision made with a scalpel at the level of the vesicouterine fold is carried down to the fetal membranes and extended bilaterally with digital traction or scissors (Figure D). A bladder flap is not developed (unless the vesicouterine fold lies unusually high) nor are laparotomy pads placed in the pericolic gutters.

Amniotomy is performed and the fetus is delivered with the aid of light fundal pressure or vacuum t-



2
4



Figure B: **1** and **2.** The rectus muscles are separated in the midline by cephalocaudal digital traction to expose the peritoneum. **3** and **4.** The peritoneum is opened by digital perforation.

(Figure D).⁵ Prophylactic antibiotics and diluted oxytocin solution are administered intravenously immediately after fetal extraction. The placenta is removed with fundal pressure and traction upon the umbilical cord until spontaneous separation occurs, the uterine cavity is wiped clean, and the uterus is massaged until firm, but it is not exteriorized. When necessary, the cervix is dilated digitally to facilitate vaginal drainage (Figure E).

The edges of the uterine incision are grasped with clamps in a single-layer locking manner with No. 0 chromic suture; the suture needle penetrates the full thickness of the myometrium, but avoids the endometrial lining (Figure E). The adnexa then are inspected and the pelvis is lavaged of blood, amniotic fluid, and any meconium.

The visceral and parietal peritoneum are not closed and the rectus muscles are not reapproximated with suture. After the peritoneal edges are confirmed to be hemostatic, the fascia is closed in a continuous nonlocking fashion using No. 0 delayed-absorbable suture. The subcutaneous tissue is not closed separately. The skin is closed with either subcuticular suture or metal staples (Figure F). Ambulation and feeding are encouraged as early as possible after the surgical anesthetics have worn off. The Foley catheter is removed within six hours of surgery.

Results. Two hundred consecutive low transverse cesarean sections were performed by the Pelosi technique. All but two women were private patients. Mean patient age was 27 years (range 17 to 46 years), and mean weight was 169 pounds (range



1
3

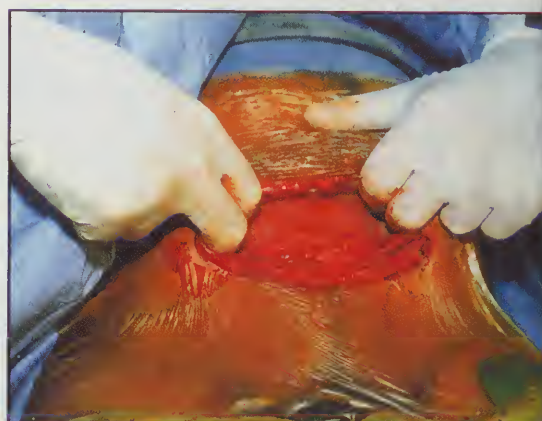
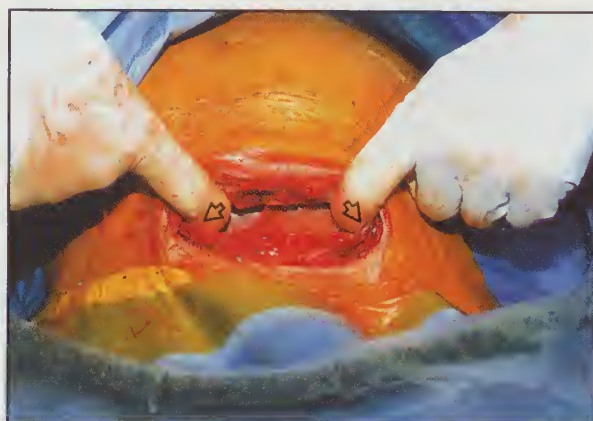
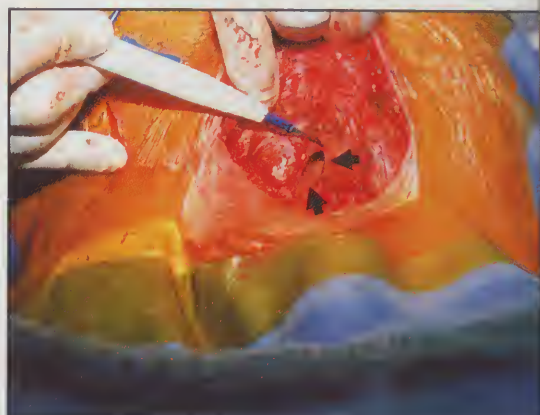
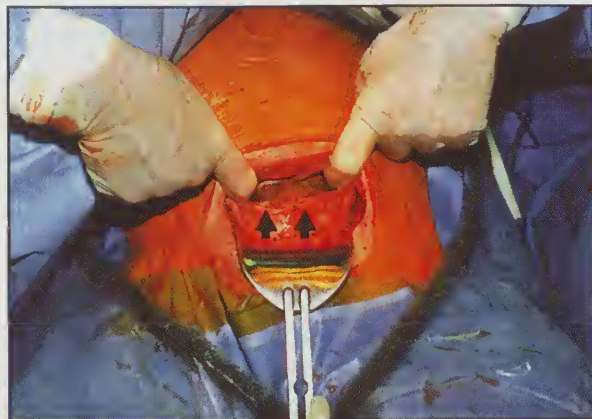
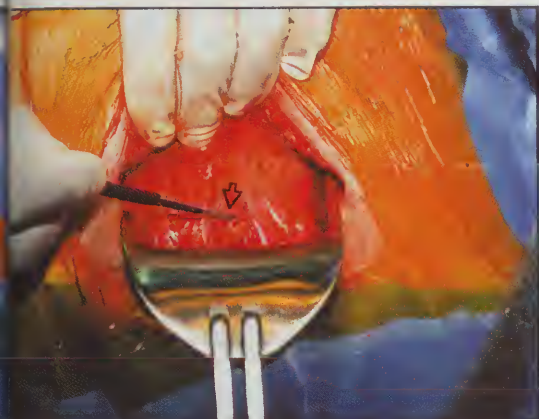


Figure C: **1.** The peritoneum is opened digitally; it is extended by lateral traction. **2.** Thickened or scarred peritoneum (arrows) is best divided sharply or electrocauterized prior to traction. **3** and **4.** The full thickness of the incision is stretched with pressure applied bilaterally (arrows).

112 to 414 pounds). Indications for abdominal delivery included dystocia or failure to progress in labor (38 percent), repeat cesarean (32 percent), malpresentation (11.5 percent), fetal distress (9.5 percent), and other (9 percent). Anesthesia for delivery was either regional (79 percent) or general (21 percent). Mean operating time was 16 minutes (range 9 to 33 minutes) and mean estimated blood loss was 460 mL (range 100 to 1,150 mL). Mean postoperative analgesic intake (oxycodone 5 mg with acetaminophen 325 mg tablet) in the hospital was 4.2 tablets per day (range 0 to 12 tablets). Mean postsurgical hospitalization time was 72 hours (range 36 to 120 hours). No bowel, bladder, or vascular injuries occurred. Additional procedures included adhesiolysis, tubal sterilization, adnexal surgery, myomectomy, and appendectomy.

Postoperative febrile morbidity occurred in one patient (0.5 percent), ileus occurred in one patient (0.5 percent), and blood transfusion was administered to one patient (0.5 percent). Two patients (1 percent) required intermittent catheterization on the first postoperative day for voiding difficulty. No cases of wound infection, wound dehiscence, hematoma, or incisional hernia occurred. All patients were ambulatory on the first postoperative day. All but one patient tolerated a regular diet on the first postoperative day. Outpatient followup yielded no incisional, intra-abdominal, or pelvic complications within the 12-week postoperative interval.

Discussion. Although Pfannenstiel's incision is frequently employed for pelvic surgery, it involves



2
4

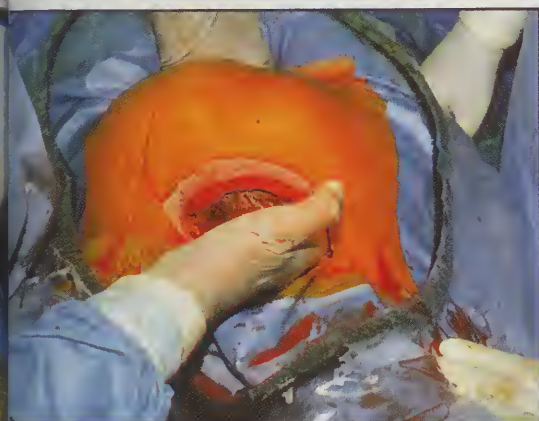


Figure D: **1.** Without the creation of a bladder flap, a 1 cm transverse hysterotomy is made at the level of the outer uterine peritoneal reflection (arrow). **2.** The hysterotomy (arrows) is extended digitally or with scissors in conventional fashion. **3** and **4.** Delivery is effected in either standard fashion or, if desired, by vacuum traction (ex presentations only).

consuming, traumatic, and bloody separation of the fascia from the rectus muscles and linea alba along the midline from the symphysis pubis to the umbilicus. In late pregnancy, however, the relative laxity of the rectus muscles obviates the need for such extensive dissection and sufficient exposure for low transverse cesarean delivery can be generated more efficiently with minimal effort, minimal bleeding, and minimal time by simply retracting these muscles laterally.

The Joel-Cohen incision, introduced for hysterectomy in the early 1970s, was one attempt to streamline the transverse laparotomy based upon this principle.⁶ In brief, a full length transverse skin incision is made superficially. Second, the transverse incision is

carried down through the subcutaneous fat and rectus fascia, but only in the middle two centimeters. Third, the rectus fascia incision is blindly extended to the full length of the skin incision bilaterally with scissors beneath the intact lateral subcutaneous fat, which is not incised. Finally, the peritoneum is opened and the rectus muscles are separated with traction. When German surgeons adapted this technique to cesarean section in the early 1980s, they found it useful in thin patients, but less effective in the presence of obesity or abdominal wall scarring.⁷ This method, although rapid, involves the blind sharp division of the lateral aspect of the anterior rectus sheath where bleeding from the fascial angles may be hidden beneath the undivided subcutaneous fat



1
3

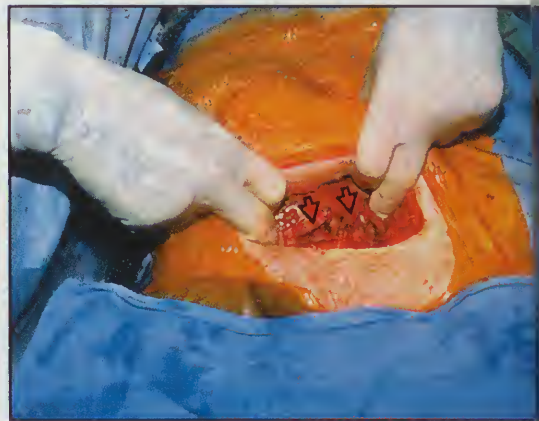
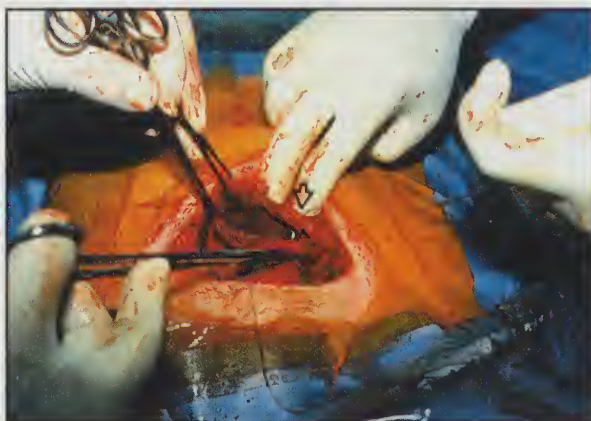


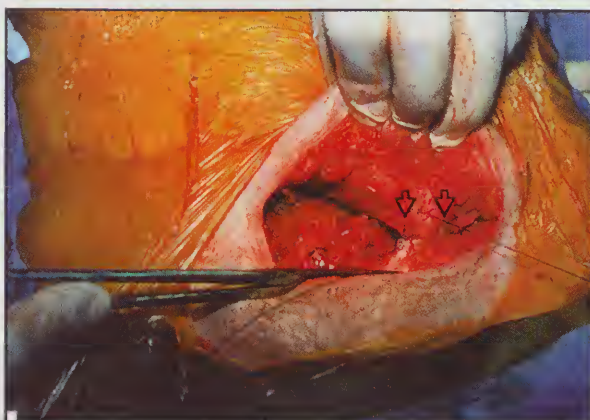
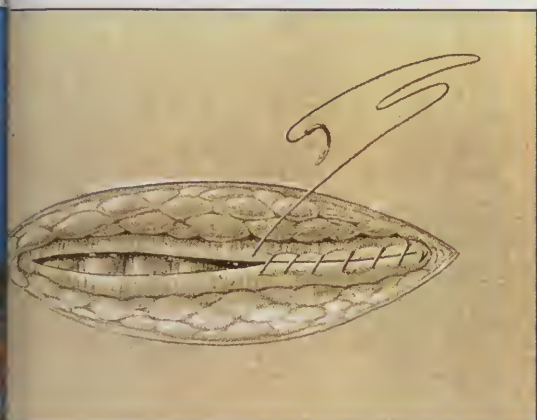
Figure E: 1. Delivery is completed. 2. The placenta is removed by fundal pressure and light cord traction following spontaneous separation. 3. Following inspection and cleaning of the uterine cavity, the hysterotomy is repaired in situ in a single layer; the endometrial lining is avoided. 4. Hemostasis is assessed and, when necessary, individual figure-of-eight sutures are placed. No suture approximation of the visceral peritoneum, fetal peritoneum, or rectus muscles is performed.

predisposing to hematoma formation. This drawback may explain, to some extent, the febrile morbidity rates (7.4 percent and 22.7 percent) and the wound morbidity rate (8.7 percent) noted in cesarean studies of this incision.^{8,9}

We consider it surgically unsound to compromise hemostasis for the sake of speed. The Bovie electro-surgical device produces a rapid, hemostatic transection of the subcutaneous fat and the rectus sheath without resort to blind maneuvers. It provides immediate control of vasculature in the incision line without the necessity to waste time searching for transected blood vessels or reaching for additional instrumentation—especially in obese patients.

Speed, with our technique, is a byproduct of absolute hemostasis afforded by electro-surgery. With entry, the excellent exposure created by the approach, the elimination of needless, extensive dissection, and the greatly reduced need for subsequent hemostatic efforts during abdominal closure. Most importantly, our technique is not limited by extreme obesity. Electro-surgical incisions have been demonstrated to heal as well as sharp incisions in large studies.^{10,11}

The bladder flap is omitted unless the vesicouterine fold lies unusually high. The bladder flap, at subsequent closure, evolved as a means of sealing off the peritoneal cavity from an infected uterine



2
4

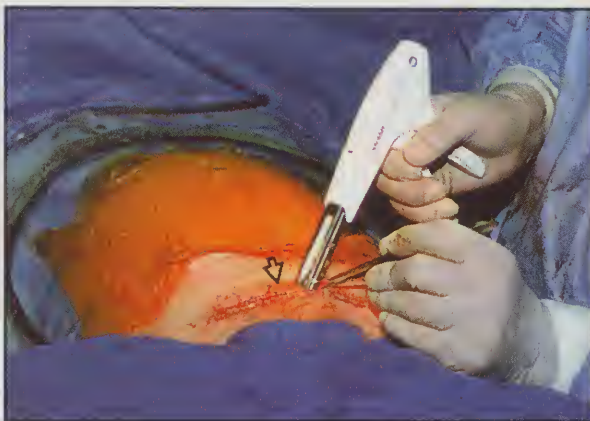
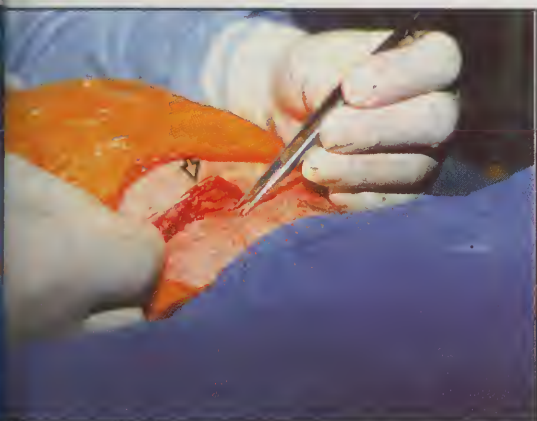
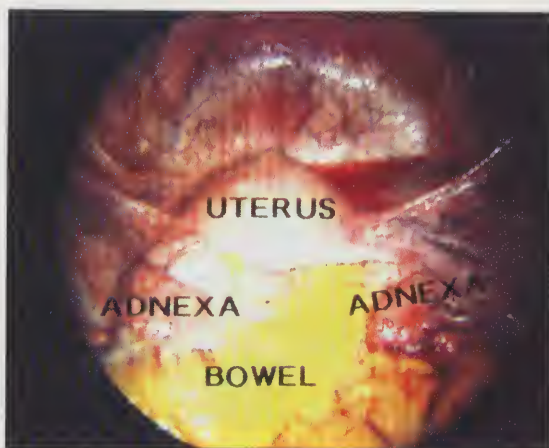


Figure F: 1 and 2. The fascia is closed in a continuous, nonlocking fashion with delayed-absorbable sutures placed at least 1 cm from the fascial wound edge (arrows). The skin is closed with either **3.** subcuticular sutures, or metal staples.

the pre-antibiotic era, not as a means of ensuring a hysterotomy incision on the lower uterine segment.¹² With downward traction on the vesicouterine fold, an incision at this junction opens the uterus within the lower segment without jeopardy to the bladder and eliminates the need to dissect through a potentially vascular area. Furthermore, the ease with which the vesicouterine fold can be reflected after delivery for ligation of the ascending branches of the uterine arteries in cases of hemorrhage suggests that such a practice can be safely reserved as a therapeutic rather than as a prophylactic maneuver. It is evident that a plane, which is well developed, will remain an anatomically intact plane less prone to dissection-related injury, potentially less bleeding, and scarring.

The avoidance of laparotomy pads in the paracolic gutters diminishes peritoneal abrasion and irritation, especially of the bowel serosa. This seemingly minor detail may account to some degree for the rapid resumption of a regular diet and ambulation in these patients.

Uterine closure in a single layer is an established technique that has been found safe in subsequent labor trials.¹³⁻¹⁶ It provides a fast, secure closure of the lower uterine segment with a markedly reduced need for subsequent hemostatic suturing as compared to the double-layer technique. Uterine closure in situ decreases the amount of manipulation to which the serosal surfaces are subjected and is easily mastered.¹⁷ Traction on both the uterine incision and on the approximating sutures makes this a very simple maneuver.



1
3

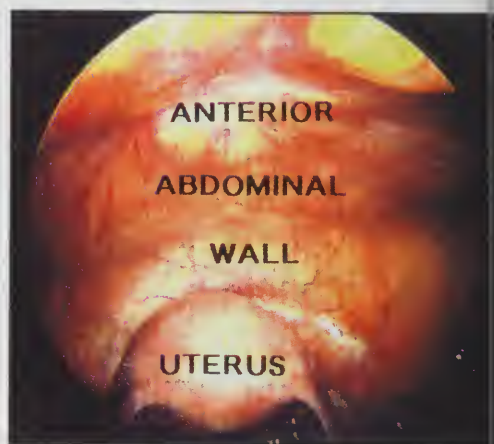
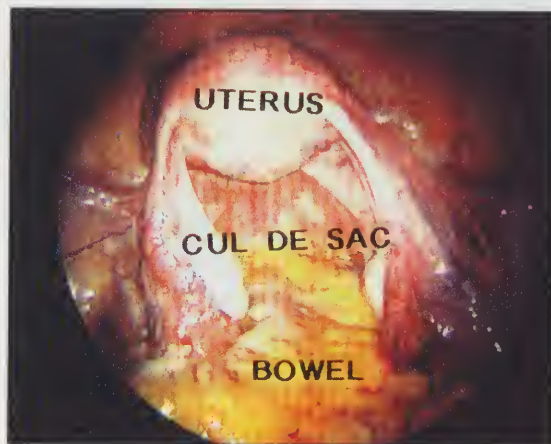
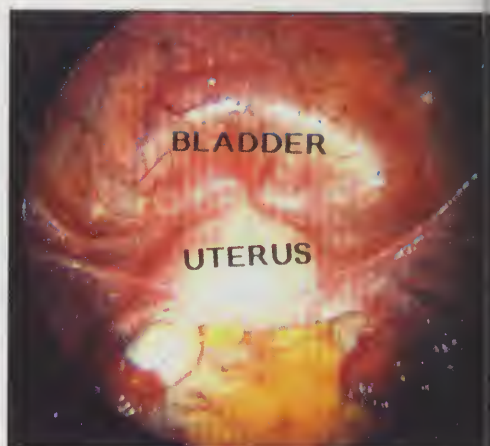


Figure G: Laparoscopy for interval sterilization subsequent to three cesarean sections by the authors' method reveals no significant pelvic adhesions: **1.** view with uterus in mid-position, **2.** view with uterus in retroversion, **3.** view with uterus in anteversion, **4.** panoramic view of pelvis and lower abdominal wall.

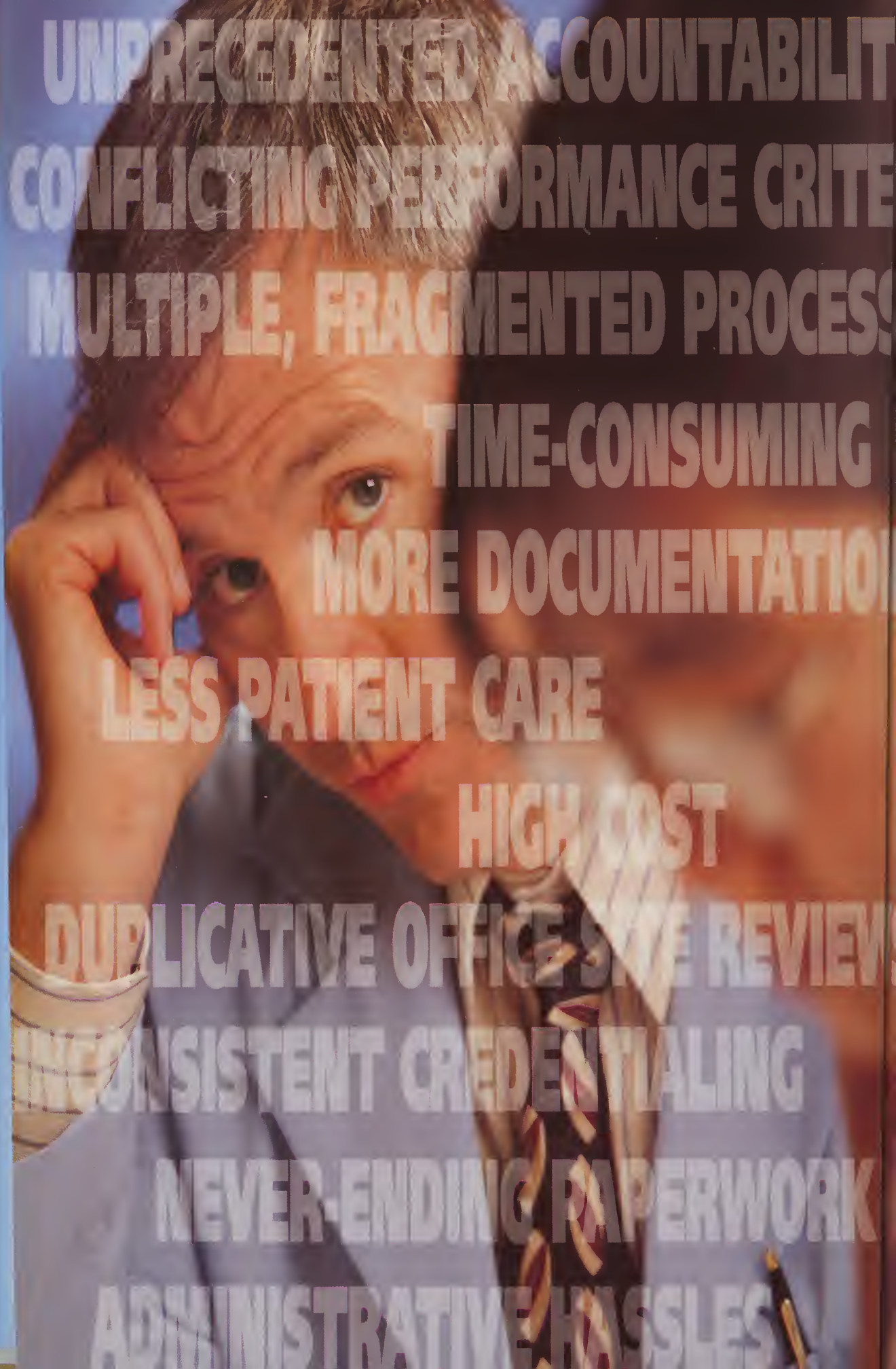
Nonclosure of the peritoneum is a widespread surgical practice supported by a broad clinical experience suggesting no adverse effect and a reduction in subsequent adhesion formation.^{18,20} Several patients undergoing laparoscopic sterilization subsequent to cesarean section by the authors' technique have demonstrated minimal intraperitoneal adhesions (Figure G). Similarly, nonreapproximation of the rectus muscles has not been found necessary or detrimental in any way. Ventral herniation has not been encountered.

Despite the limitations of a single-team retrospective surgical study, we conclude that the Pelosi method of cesarean delivery is safely executed and is associated with a very low incidence of febrile morbidity and of other postoperative complications

generally attributed to cesarean delivery by other methods. Performance of the operation is not impaired by morbid obesity or by scarring from previous abdominal surgery. We have observed early tolerance of a regular diet and early ambulation, which are typical for patients subjected to this method of abdominal delivery. As a fringe benefit of increased technical efficiency, we also have observed decreased operating times and the need for few sutures, less extensive dissection, less potential for serious complications, less serous drainage from denuded surfaces, less surgical material, and shorter operating times are inherent to the technique and are factors well known to diminish the risk of wound infection and to enhance recovery for these patients.

References

1. Katz VL, Cefalo RC: History and evolution of cesarean delivery, in, Phelan JP, Clark SL (eds), *Cesarean Delivery*. New York, NY, Elsevier, 1988.
2. Rayburn WF, Schwartz WJ III: Refinements in performing a cesarean delivery. *Obstet Gynecol Survey* 51:455-451, 1996.
3. Pelosi MA, Pelosi MA III: Simplified cesarean section. *Contemp Ob Gyn* 40:89-100, 1995.
4. Pelosi MA, Ortega I: Cesarean section: Pelosi's simplified technique. *Rev Chil Obstet Gynecol* 59:372-377, 1994.
5. Pelosi MA, Apuzzio J: Use of the silicone obstetrical vacuum cup for delivery of head at cesarean section. *J Reprod Med* 29:289-293, 1984.
6. Cohen SJ: *Abdominal and Vaginal Hysterectomy*. London, England, William Heinemann Medical Books, 1972.
7. Kaser O, Ikle FA, Hirsch HA: *Atlas of Gynecologic Surgery, 2nd English Edition*. New York, NY, Thieme-Stratton, 1985.
8. Stark M, Finkel AR: Comparison between the Joel-Cohen and Pfannenstiel incisions in cesarean section. *Eur J Obstet Gynecol Reprod Biol* 53:121-122, 1994.
9. Ferrari A, Frigerio L, Origoni M, et al.: Modified Stark procedure for cesarean section. *J Pelvic Surg* 2:239-244, 1996.
10. Hemsell DL, et al.: Abdominal wound problems after hysterectomy with electrocautery versus scalpel subcutaneous incision. *Infect Dis Obstet Gynecol* 1:27, 1993.
11. Johnson CD, Serpell JW: Wound infection after abdominal incision with scalpel or diathermy. *Br J Surg* 77:626, 1990.
12. Ricci JV, Marr JP: *Principles of Extraperitoneal Cesarean Section*. Philadelphia, PA, The Blakiston Company, 1942.
13. Jelsema RD, Wittinger JA, et al.: Continuous, nonlocking, single-layer repair of the low transverse uterine incision. *J Reprod Med* 38:393, 1993.
14. Hauth JC, Owen J, et al.: Transverse uterine incision closure: One versus two layers. *Am J Obstet Gynecol* 167: 1108-1111, 1992.
15. Tucker JM, Hauth JC, et al.: Trial of labor after a one- or two-layer closure of a low transverse uterine incision. *Am J Obstet Gynecol* 168:545-546, 1993.
16. Chapman SJ, Owen J, Hauth JC: One- versus two-layer closure of a low transverse cesarean: The next pregnancy. *Obstet Gynecol* 89:16-28, 1997.
17. Magann EF, Dodson MK, et al.: Blood loss at the time of cesarean section by method of placental removal and exteriorization versus in situ repair of the uterine incision. *Surg Gynecol Obstet* 177:389-392, 1993.
18. Hull DB, Varner MW: A randomized study of closure of the peritoneum at cesarean delivery. *Obstet Gynecol* 77:818-821, 1991.
19. Pietrantonio M, Parsons MT, et al.: Peritoneal closure or non-closure at cesarean. *Obstet Gynecol* 77:293-296, 1991.
20. Elkins TE, Stovall TG, et al.: Histological evaluation of peritoneal injury and repair: Implications for adhesion formation. *Obstet Gynecol* 70:225-258, 1987.



UNPRECEDENTED ACCOUNTABILITY

CONFLICTING PERFORMANCE CRITERIA

MULTIPLE, FRAGMENTED PROCESSES

TIME-CONSUMING

MORE DOCUMENTATION

LESS PATIENT CARE

HIGH COST

DUPLICATIVE OFFICE SITE REVIEWS

INCONSISTENT CREDENTIALING

NEVER-ENDING PAPERWORK

ADMINISTRATIVE HASSLES

Our solution has arrived.

One Time

One Source

One Standard



American
Medical
Accreditation
Program

new American Medical Accreditation Program (AMAP), physicians
an application **ONE TIME**, have their credentials primary-source
ONE TIME, and have an on-site office review **ONE TIME**.

en provides an Accreditation report and certificate to each physician
is the AMAP national standard.

AP will provide a complete portfolio of verified credentials, office site
d other frequently requested information to each health plan and
that uses AMAP and with whom the physician is affiliated.

ican Medical Accreditation Program is a voluntary, comprehensive
ion program that measures and evaluates individual physicians
ational standards, criteria and peer performance in five areas:
als, Personal Qualifications, Environment of Care,
Performance, and Patient Care Results.

Meeting and maintaining AMAP's high standard earns a physician AMAP
Accreditation – a new national benchmark of physician quality.

AMAP, your one source for the new national standard of physician quality
information, has arrived.

To learn more about the many benefits
AMAP has to offer *your* organization,
call the AMAP Resource Center at
1-888-881-AMAP (2627) or visit the AMAP
Web site at <http://www.ama-assn.org>.

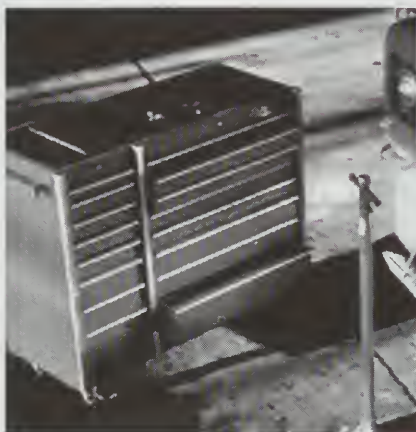


The standard in quality physician care.

American Medical Association
Physicians dedicated to the health of America



Only MIIX offers



the Toolkit that fits in your briefcase.

Provided by MIIX Financial Services

The MIIX Toolkit, designed specifically for physicians, explains how you can access:

- **MIIX Buying Service** — offering discounts up to 70% on quality medical and office supplies and equipment.
- **Equipment Leasing** — equipment lease financing and lines of credit at competitive rates.
- **Receivables Management** — providing collection of medical accounts receivable.
- **MIIX Capital Management** — investment consulting services for physicians and other high net worth individuals.

To find out more about this powerful resource,
call MIIX Financial Services at

1-800-227-MIIX.

Endorsed by the

Medical Society of New Jersey

MSNJ

M E D I C A L I N T E R - I N S U R A N C E E X C H A N G E
P O W E R F U L P A R T N E R S H I P S



ADVANCES

Molly Davis

PUTTING MONEY WHERE THE DISEASE IS: DIABETES RESEARCH

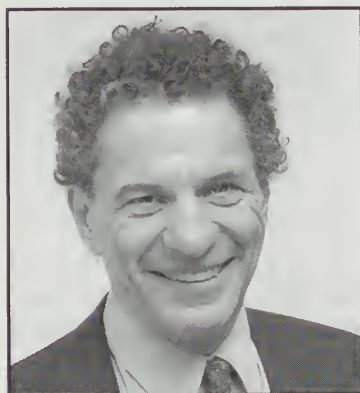
Of the 16 million people in the United States with diabetes, one-half do not realize it, according to George P. Gewirtz, MD, endocrinologist and medical director of Joslin Center for Diabetes at the St. Barnabas Healthcare System. So what is being done to recognize the undiagnosed? And since so much money is put into diabetes research every year, what are the advances in treatment?

"One of the reasons that diabetes is the most funded disease is because it's a very common interest," said Gewirtz. "One of the challenges is to find out who has it. Another challenge is that diabetes is an extremely expensive illness—in terms of medical costs, it's a major expense."

There are two types of diabetes. Type 1, known as juvenile diabetes, makes up 5 percent of total diabetics. With this illness, the cells in the pancreas that produce insulin are destroyed. Type 1 usually occurs

in people under the age of 30 but it can happen at any age. "All the people with this particular type of diabetes take insulin because the pancreas cannot produce it," said Gewirtz.

Type 2, known as adult-onset diabetes, develops in people over age 30 and can be attributed to obesity. The insulin being produced is not as effective as it should be in bringing the blood sugar level down to normal—the body resists



George P. Gewirtz, MD

insulin. The second factor is that the insulin is not released in a normal fashion. The upside to Type 2 is that there are many treatment options, including controlled diet and regulated insulin.

The Diabetes Control and Complications Trial (DCCT) Stu-

dy, completed in 1994, studied patients with Type 1 diabetes. The trial was to be a ten-year look at the relationship between blood sugar and complications. Researchers asked the question, "If the blood sugar is better controlled, will there be fewer complications with diabetes, such as problems with eyesight, kidneys, and nerve endings (neuropathy), all which may lead to infection?"

According to Arthur Krosnick, MD, of the Princeton Joslin Center for Diabetes, the study was very well received: "It was a landmark research study that engraved in stone the understanding that intensive control of the blood sugar level in Type 1 diabetics could prevent or delay the microvascular complications of diabetes including diabetic retinopathy, neuropathy, and nephropathy. They had suggestive evidence that it also would benefit Type 2 diabetics. There was another study done in Japan with Type 2 diabetes that confirmed intensive control of the blood sugar level would delay or prevent the complications of diabetes."

"It was fabulously well received and it was flashed all

over the world," noted Krosnick. "Although the study was supposed to last for ten years, the data were so strong on the basis of human response, the study was suspended so the findings could be released to the entire world—which accepted it immediately."

There is a higher incidence of a wide range of complications in Type 1, like microvascular complications, macrovascular complications, stroke, and heart disease. The DCCT Study showed that the more effectively the blood sugar level is controlled, the less likely the patient is to develop these complications. There have been subsequent studies that also have confirmed these studies for Type 2.

"A lot of the money has gone toward finding out about the disease and understanding the types," said Gewirtz. "Until you understand the basics, it's hard to develop treatment. But when you understand the causes, research can be directed toward prevention."

The National Institutes of Health (NIH) in Washington, DC, is studying Type 1; NIH is trying to identify who might develop diabetes because the disease is a slow process that occurs over a period of years and the illness tends to run in families. There also are studies

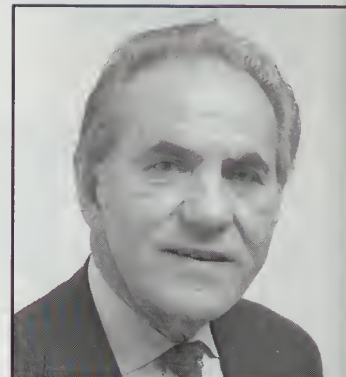
with simple forms of oral insulin that are considered preventive.

For Type 2, NIH is attempting to see whether Type 2 can be prevented by analyzing signs in the blood, such as slightly raised blood sugar, with diet, exercise, and medication.

Other advances are focusing on bringing blood sugars as close to normal as possible with education, diet, exercise, and insulin using machines that monitor blood sugar at home, including insulin pumps.

New forms of insulin also have been introduced such as Lispro[®], a rapid-acting insulin that allows a person to control blood sugar more precisely.

"In Type 2 there has been an explosion in new forms of treatment," said Gewirtz. The medical community is beginning to understand what causes the problem and is developing drugs that treat the problem. There are sulfonylureas, an oral group of drugs that stimulates the pancreas to produce more insulin. Recently, newer drugs have been introduced that decrease insulin resistance, by preventing the liver from releasing sugars into the bloodstream, and drugs that decrease insulin resistance in the muscles so that the muscles can absorb sugar from the bloodstream more easily. Patients use



Arthur Krosnick, MD

the drugs together or with insulin.

"We're learning much more about how to treat diabetes," Gewirtz added. "In diagnosing, the level of blood sugar that defines whether or not you have diabetes were lowered. In comparison, this is more advanced than the old ways of diagnosing and for the current complications, people don't have to go through glucose tolerance testing anymore and it's much easier to identify." By identifying earlier, the 8 million undiagnosed diabetics can start treatment earlier so as to prevent or delay complications.

According to the American Diabetes Association (ADA), it has been almost 20 years since the previous guidelines for diagnosing diabetics were released. They were published in 1979 and developed by the National Diabetes Data Group under the auspices of the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDKD) of NIH.

Over the years, considerable research has provided greater insight into how and why diabetes and its complications develop.

"Since 1957, we have known that for every known diabetic in America there is one unknown diabetic," said Krosnick. "We have struggled with various techniques but finally the experts realized that the criteria for diagnosing were too high—they needed to be revised; as of June 1997, the world has accepted the new criteria."

Three years ago, the ADA convened 17 international experts to review 15 years of research and to develop a report. Their report was reviewed widely in the diabetes community prior to completion. The guidelines were published in the July 1997 issue of *Diabetes Care*, together with a supportive editorial and in the August 1997 issue of *Annals of Internal Medicine*. The report's recommendations have been accepted and supported by the Division of Diabetes Translation of the Centers for Disease Control and Prevention, and by NIDDKD. Other organizations currently are reviewing the expert committee's report, and there is indication of wide support of the

guidelines in the diabetes and broader medical communities.

"The report was immediately utilized by primary care physicians," added Krosnick. "If they didn't use the new criteria, they would be missing many patients and that was the number one message. The other aspect of the report was that it confirmed the fact that it is important to do blood testing not only after breakfast but after a challenge of food to see how high the blood sugar gets after eating. Another point is that the new guidelines re-emphasize that there are certain people at higher risk, such as African-Americans, Hispanics, Asian-Americans, Native American Indians, people with a family history of diabetes, and women who have had a large baby (over nine pounds)."

Any one of three tests that diagnoses diabetes can be used: fasting plasma glucose (FPG), a simple blood test done after not eating for eight hours; a casual plasma glucose, a simple blood test done at any time, regardless of eating; or an oral glucose tolerance test (OGTT), in which blood sugar levels are evaluated two hours after the person is given a drink containing 75 g of anhydrous glucose dissolved in water. In the past, OGTT was preferred. Today, the experts say the FPG

is preferred because it is simpler, less expensive, and more acceptable to patients and, therefore, more likely to be offered on a regular basis.

It is hoped that these new guidelines will call attention to people's risk of diabetes due to a genetic component and will encourage them to have periodic screening for the disease.

"I think the research money is being well spent," Gewirtz said. "If we understand the illness, we can definitely prevent or delay the devastating complications of diabetes."

"Patients are getting very well educated so they know all about advances when they come out," said Krosnick. "Pharmaceutical companies place full-page advertisements in newspapers and what happens is patients will tear the ads out and go to their doctor and say 'I want to take this medicine.' Many times the patient will know about something before the doctor does."

It is hoped the new guidelines will help to diagnose the large number of people who do not know they have the illness. In New Jersey, there are 250,000 people currently diagnosed with diabetes and under treatment. There also is an equal number of

NJM

Malpractice insurance policies are strange animals. Beware of the ones with tails.

Most New Jersey malpractice insurance policies require you to purchase a reporting endorsement — known as a tail — to protect against claims that may occur during retirement. B.C. Szerlip offers a unique policy from an A+ rated company that does not include an annual tail premium. In fact, if you maintain coverage with us until retirement, you'll *never* have to purchase a tail, and you'll still be protected.

That's just one example of the creative ways that B.C. Szerlip has discovered to help doctors with their long-range financial planning.

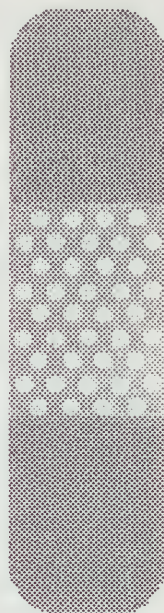
At B.C. Szerlip, we take a big-picture view of your practice, offering you comprehensive insurance and financial planning services. You can benefit from our nearly two decades of experience providing malpractice insurance for medical offices both large and small. In addition, our financial planners can offer strategic guidance for the overall health of your business affairs, so you can stay focused on the health of your patients.

We'd like to give you a taste of our full-service approach by sending you *The Managed Care Survival Kit for Physicians*. To receive your complimentary copy of this useful guide, please call us at 800-684-0876.

BCSZERLIP INSURANCE AGENCY INC.

99 WOOD AVENUE SOUTH, PO BOX 217
ISELIN, NJ 08830-0217
800-684-0876 • 732-205-9800
FAX: 732-205-9496
E-MAIL: bcszerlip@aol.com

*Professional Insurance Services
for Health Care Providers*



YOUR OFFICE WHERE DOES HURT?

STAFF?
BILLING?
INSURANCE?
COLLECTIONS?
CPT/ICD CODES?
CODING UPDATES?

Your office will be evaluated and reorganized to operate with peak performance and efficiency, confidently and expertly. What may be causing your daily office routines to be deficient ... will be diagnosed, examined and cured. Call for intensive care and expertise.

MARY ANN HAMBURGER

A S S O C I A T E S

THE SPECIALIST'S SPECIALIST

74 HUDSON AVE. MAPLEWOOD, N.J. 07040
973-763-7394

You take care of your patients. We'll take care of the health of your practice. Our group of health care accounting specialists provides the medical community with the right type of analysis and counseling to be successful.

Since we're dedicated to increasing your profitability, never simply reporting it, we'll see

to it that your practice stays healthy for many years to come. To experience our unique approach, please call Ira S. Rosenbloom, Managing Director, at 973-882-1100.

PRactice
GOOD FINANCIAL
MEDICINE.



Mintz Rosenfeld & Company L.P.

Profitability Consultants • Certified Public Accountants

60 Route 46 East, Fairfield, NJ 07004
Tel: 973-882-1100 Fax: 973-882-1560

OUR FOCUS IS YOUR SUCCESS.

ADVANCES

Bill Berlin, PhD

PROSTATE CANCER: IS THE PSA TEST THE ANSWER?

Peter Doherty believes that the prostate specific antigen (PSA) test gave him back his life. Doherty, a retired corporate executive, was diagnosed with prostate cancer six years ago after his PSA came back with a reading of 18. A lean, energetic 70-year old, Doherty recently organized a prostate cancer "summit" in New Jersey, and is an ardent advocate of PSA screening.

"I wouldn't be alive now without the PSA test," Doherty says firmly. "It's given me six years of living."

But Doherty's passion is not matched throughout the medical world, where the PSA test evokes decidedly mixed feelings among clinicians and professional organizations. While the American Urological Association and the American Cancer Society endorse the PSA test as a screening tool for prostate cancer, other organi-

zations, such as the United States Preventive Services Task Force and the National Cancer Institute, do not. Still other organizations, most notably the American College of Physicians, urge that the decision to screen using the PSA test be made on an individual basis.

One thing that is less disputable is that prostate cancer is a serious issue for American males. The prostate gland, located just above the neck of the bladder and the rectum (from the term "prostate," derived from Greek, "standing before"), produces an alkaline fluid that is a primary component of semen. This walnut-shaped gland is a major site of cancer in men, with an estimated 209,000 new cases in 1997 and 41,800 deaths. Prostate cancer is the second most commonly diagnosed malignancy after superficial skin cancer, and the second leading cause of cancer deaths in American males after lung cancer.

Prostate cancer risk seems to vary with race and geography. Mortality rates among African-

American males are more than twice those of other men, and their incidence rates are the highest in the world. Prostate cancer is relatively rare in much of Africa, Latin America, and the Near East, and more common in North America and Western Europe. Studies of Japanese men who have relocated to Hawaii or the mainland United States show a significant increase in prostate cancer, suggesting that dietary and environmental factors may heighten risk.

Although the prostate cancer death rate increased by 25 percent between the 1971-1973 period and 1991-1993, the mortality rate declined by 6.3 percent between 1990 and 1995. To Doherty and other prostate cancer activists, this drop reflects the impact of early screening: the PSA test in combination with the digital rectal examination (DRE). Supporting his view is the fact that the number of men diagnosed with prostate cancer actually increased from 96,000 in 1987 to 132,000 in 1992.

The PSA test, which measures an enzyme that liquifies semen, has been increasingly employed as a screening tool during the last decade. The PSA test often has been administered to men age 50 and over, and has been recommended for African-American males and for men with a family history of prostate cancer who are 45 and older.

Generally, results falling between 0 and 4.0 ng/ml have been considered normal, with cancer risk increasing incrementally with higher readings. But like many issues surrounding prostate cancer, the efficacy of the PSA test is clouded by conflicting claims, confusing data, and a lack of conclusive research.

To some clinical urologists, like Medical Society of New Jersey (MSNJ) member Anthony Catanese, MD, who chairs the American Cancer Society's Prostate Cancer Task Force, the PSA test is a valuable tool in diagnosing and treating cancer. "The PSA test is an extremely strong screening test in the right hands," Catanese says, "but it has the potential to be abused out of ignorance, fear, or even for

profit." Catanese notes that the PSA test, used in combination with the DRE, will discover 50 percent of all prostate cancers.

But to critics of the PSA test, a high diagnostic rate is unpersuasive, and perhaps even unfair to those diagnosed. For one thing, the PSA test produces a high rate of false-positives, usually finding no cancer at all or tumors that are not localized or treatable. "Don't forget that the cancer you're looking for with the PSA test is curable prostate cancer," warns MSNJ member David Swee, MD, chair of the Department of Family Medicine at UMDNJ-Robert Wood Johnson Medical School, "which has a much lower incidence than prostate cancer itself." Epidemiological studies suggest that 30 to 40 percent of men over 50 may have prostate cancer of some type. However, only 20 to 25 percent of these cancers are "clinically significant," and an estimated one out of ten men who have prostate cancer will die from the disease.

In a 1997 position paper on clinical guidelines for prostate cancer screening, the American College of Physicians

(ACP), emphasized an "absence of evidence from controlled studies showing that screening reduces mortality related to prostate cancer." Since the malignancy usually grows very slowly, treating older men with less than a ten year life expectancy may make little sense. And in some cases, treatment may cause more harm—both physical and psychological—than good.

A PSA test, in itself, is not expensive, averaging \$30 to \$40, and some states, including New Jersey, mandate insurance coverage of at least one assay for men over the age of 50. Starting in the year 2000, Medicare also will cover the test. However, the implied cost of the PSA test, including the DRE, followup evaluations, needle biopsies, and possible treatments, can be substantial, with estimates ranging from \$161 to \$414, depending on the age of the patient. Given the high number of cases that go untreated, and the greater mortality from such



David Swee

diseases as lung cancer or heart disease, some observers argue that this money would be better spent in other areas.

Perhaps the strongest argument against the PSA test is that there is no proved, effective cure for prostate cancer. Why try to detect a disease that cannot be treated? Why put men at risk of incontinence and impotency—frequent side effects of radiation therapy and radical prostatectomy—if the treatment itself offers little or no hope?

Here the urology profession diverges sharply from the primary care community. "Most urologists believe that we do have very reasonable treatments and cures, and if we don't cure them we can prolong their lives," says Catanese. "But prostate cancer grows so slowly that it takes 10 to 15 years to get the results of a study."

A crucial problem, then, is that research into the efficacy of radical prostatectomies and other treatments is ongoing and no definitive conclusions can yet be drawn. However, the American Cancer Society bases its PSA test recommendations in part on what it refers to as "compelling intermediate

data from non-randomized studies."

Catanese says that the PSA test helps him find six or seven cases a year, which he has cured, but have not yet entered the statistical profile of the disease. A key to early detection, he emphasizes, is a marked increase in PSA, with a single test being of little use except as a potential baseline against which future assays can be compared. Catanese sees a need for more sophisticated PSA test guidelines related to age and race, and geared to changes over time, the ratio of free to bound PSA, and an estimated size of the prostate gland. Moreover, the PSA test and DRE should be administered by a seasoned clinician who can interpret results on a case-by-case basis.

Where does all this leave the primary care physician? Some physicians may face an ethical quandary when patients request a PSA test without fully comprehending the implications of the examination. Worried about the legal consequences of refusing an examination to a patient who later develops prostate cancer, physicians may authorize a test they may not truly endorse. On

the other hand, while the PSA test may not pass a cost-benefit macro-analysis, it may lead to effective treatment of some men with localized cancers.

Some, like Swee, believe that an "informed decision-making" approach works best with patients when it comes to the PSA and other screening tests. Physicians should inform their patients of both the limitations and benefits of screening examinations, and should not recommend tests they do not believe are medically or ethically justified. Patients need to understand the risks and ramifications of a test—in the case of the PSA test, for example, that false positives are not uncommon, or that an "abnormal" score could lead to a costly and uncomfortable needle biopsy. Physicians also should discuss the issues surrounding treatment options, and the lack of firm research regarding results.

All of this might take five or ten minutes to discuss with a patient, and Swee views it as time well spent. "There's good evidence that showing patients the data and doing a risk-benefit analysis," he says, "helps patients make good decisions."

NJM

232nd MSNJ Annual Meeting

April 28-May 2, 1998

**Trump Taj Mahal
Casino/Resort
Atlantic City
1-800-825-8888**

ARE YOU ENTITLED TO A REAL PROPERTY TAX REBATE?

Robert J. Cirafesi, Esq
Michael F. Schaff, Esq

Do you own your office or other commercial real estate? If the answer is yes, there are certain steps you can take that may reduce your local real property assessment, resulting in reduced property taxes in the future and a possible tax rebate.

Property tax time. The real estate tax assessment figure on the notice of assessment is prepared by a local municipality; it does not necessarily reflect the true value of a building and land but only the value upon which the local municipality assesses and taxes an individual owner.

Property tax computation. Your assessment, in theory, is based upon a fair market value determination by the local assessor. However, each municipality determines its tax base by using a ratio of assessed value versus fair market value. However, the 1998 assessed value, based perhaps on an inflated real

estate market of the past, may not truly reflect lower real estate values prevalent today. This may result in additional taxes levied upon a property.

To determine the fair market value from the assessed value,



convert the ratio to a fraction with its numerator being the ratio and its denominator being 100; divide the assessed value by the fraction. If you believe that the resulting fair market value determined using the above formula substantially exceeds the property's fair market value, then there may be a tax savings available. You may appeal an assessed value and be entitled to a rebate.

Example. You have an office in Millburn Township assessed at \$500,000. Millburn Township has a ratio of 45.94 percent, making a fair market value of \$500,000/.4594, or \$1,088,376.

Your appeal. Under New Jersey law, taxpayers feeling aggrieved by the assessed valuation of real property may appeal that assessment. In order to bring an appeal, all prior municipal charges, including first quarter taxes, must be current and a petition must be filed with a county tax board or with the New Jersey Tax Court no later than April 1, 1998.

Attorneys usually accept these types of cases on a contingent fee basis. Petitioners need pay only a percentage of the abatement savings. If you do not achieve a reduction, and there are no savings, you should not be required to pay any legal fee.

The authors are affiliated with Wilentz, Goldman & Spitzer, P.A., Woodbridge.

NJM

Here's what we are covering in April 1998

⇒ Are New Jersey blood banks safe?

Blood banks have taken a roller coaster ride in public opinion over the past 20 years. With improved testing, sophisticated computer programs, and public education campaigns, read what medical writer Sheila Smith Noonan has uncovered.

⇒ What do New Jersey adolescents know about AIDS?

Dr. Jane Miller, from the Institute for Health, Health Care Policy and Aging Research, of Rutgers University, presents research about the benefits of AIDS education for New Jersey adolescents.

⇒ What is sparking the new interest in cosmetic surgery?

Writer Robin Levinson reports on the growing interest and need for cosmetic surgery, from the patient and physician points of view.

⇒ Is DES, once known as a miracle drug, still a concern?

It is estimated that there are 305,000 DES-exposed people in New Jersey alone. Robin Rapport analyzes the effects of this exposure on future generations.

⇒ What is the role of hospice care?

The Center for Hope Hospice is just one example of how we can treat patients during the last days of life. This article uncovers the behind-the-scenes work at one of New Jersey's hospice centers.

⇒ What is repetitive stress injury and can it be prevented?

Writer Eric J. Lerner explains the accelerating epidemic of repetitive stress injury and its effects on office workers around the state.

⇒ Tune in for Mailstop, F.Y.I., Newsmakers, Editor's Desk, Online MSNJ, and Calendar.

COMMENTARY

Helping Physicians Maintain Control

David L. Knowlton

It has been almost 25 years since the passage of the federal Health Care Maintenance Act of 1973, which ushered in the era of managed care. Today, the practice of medicine has evolved into the business of medicine. As a result, physicians are turning to health care consultants for solutions to the dilemma of practicing medicine in a managed care world.

To meet this growing need, the Medical Inter-Insurance Exchange (MIIX) Healthcare Group (MHG) was formed in 1996 under the direction of Daniel Goldberg, president and chief executive officer. MHG, one of the MIIX group of companies, is endorsed by the Medical Society of New Jersey. It provides comprehensive health care consulting services and unique products designed to assist physicians, hospitals, and health care organizations in meeting the challenges created by managed care.

Today, physicians must be concerned with a variety of areas, including practice management, hospital administration, marketing, education, training, data management, insurance, law, and government. Consultants can provide practice assessment and strategic planning, practice valuations, network formation, and other services to help physicians thrive in managed care medicine.

Practice assessments. An assessment of practice operations uncovers business issues that must be addressed if a practice is to survive in a managed care world. Generally, the results of an assessment enable a practice to enhance productivity and work flow, increase revenue streams, and develop effective information, billing, and clinical systems. Recommendations may include patient satisfaction surveys to retain current patients, as well as marketing programs to expand a practice with new patients.

Recently, a specialty group practice in New Jersey approached MHG for services. On-site consultation was the first step, followed by market research on the competition, demographic data collection, and an analysis to determine how to position the practice for future growth.

There should be a comprehensive plan that identifies key marketing opportunities, a business strategy, recommendations for launching a product line, and a marketing communications plan targeted toward patient and insurers through advertising and public relations.

Managed care strategies. Whether a practice arrangement is a small primary care group or a large multispecialty group, physicians often need an objective, outside opinion to improve operations. They also need to know how to respond to the next round of developments in managed care. Strategies should be designed to enhance contract-

ing capability, practice marketability, and relationships with key players such as insurers and health care systems.

For example, capitation offers physicians the opportunity to increase revenue by providing the right care at the right time. Doctors should get assistance to design risk-based models and clinical protocols to support utilization and resource consumption. This is vital to physicians who have seen stagnant, even diminished, revenues as a result of capitation managed care.

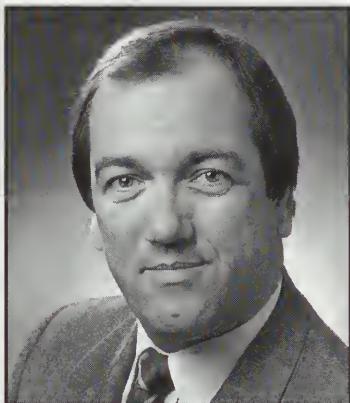
Practice valuations and operating solutions. Strategic practice valuations, ranging from specific market condi-

tions and managed care penetration to physicians' life cycles and suitable buyer availability should be created. This service gives physicians insight into their geographic market, which enables them to establish exit and alliance strategies that can work in their favor.

"For some practices, we urge the development of a long-term strategy, rather than a quick fix solution," says Pat Costante, MHG's chief operating officer. "This may mean bringing on partners or hiring new employees. And, if adding staff does not seem feasible, we can suggest exploring the option of employee leasing."

One of MHG's most sought-after programs results from its partnership with Employee Solutions, Inc. (ESI), one of the nation's leading professional employer firms. This program allows physicians to lease back their own employees, resulting in significant savings in payroll costs as well as pension and employee benefits, and fewer administrative hassles.

ESI offers services ranging from payroll management and regulatory compliance to benefits outsourcing. The advantages for physicians who implement employee leasing are increased profit margins, reduced administrative



David L. Knowlton

COMMENTARY

burdens, and consolidated practice operating expenses. Employee satisfaction also is improved through an expanded benefits package.

COMMENTARY

"Since announcing our partnership with ESI, the response has been very positive," notes Costante.

Network formation. Managed care companies looking to strengthen their market share are establishing contracts with regionally based, highly specialized physician groups. In response to this trend, MHG has pooled its resources to assist groups of specialty practices interested in forming their own network. Network formation allows physicians to contract with insurers by managing large numbers of specialty care patients and producing better patient outcomes.

One recent example is the formation of an orthopaedic resource network. Last year, a core group of orthopaedic physicians and surgeons approached MHG to launch the this network. The founding members sought to bring together physicians and managed care partners to promote a unique, high-quality, specialty network for the managed care market. The goal was to coordinate specialty care among its participating network physicians and to achieve cost containment through patient management, including diagnosis, treatment, and rehabilitation.

In forming this specialty network, a strategic plan was developed that iden-

tified key variables, such as positioning, patient and payer bases, and pricing. The plan provided recommendations for network development and addressed reimbursement issues, affiliation, and opportunities for consolidation and acquisition. Today, this is an extensive orthopaedic network operating throughout New Jersey. Its current network of more than 150 physicians is expanding to reach its objective of becoming an important player in the managed care market.

Perhaps MHG's most ambitious client for network formation is the American Academy of Clinical Endocrinologists (AACE). This organization is building a national IPA, called AACECare, currently operating in New Jersey and Georgia. AACE's goal is to position endocrinologists as the primary physicians for patients diagnosed with diabetes. AACECare offers payers better outcomes through endocrinologist-directed disease management.

Keeping pace. To survive in today's volatile health care climate, physicians need to recognize and fully manage the changes taking place. "Our staff is constantly tracking the pulse of health care, developing solutions for physicians to capitalize on these trends," says David L. Knowlton, president of MHG. "MHG is a resource for physicians seeking to build and maintain a successful practice, and allowing them to focus on providing patient care."

Mr. Knowlton is president of **NJM**
MHG.

When professional health law counsel is called for,
call the firm the experts are calling.



For years health care providers and businesses have been calling Theodosia A. Tamborlane P.C. when they needed accurate information, insightful commentary and practical advice. That's because Theodosia A. Tamborlane P.C. successfully navigates through the maze of government activity at both state and federal levels every day.

Today physicians, hospitals, nursing homes, assisted living, ambulatory care

facilities, home health care agencies and other providers turn to this firm for legal services including managed care contracting and corporate compliance plans. It's little wonder why leading health law publications and the nation's most prestigious legal, medical and business associations keep calling Theodosia A. Tamborlane P.C. to keep their members up to date. When you need professional legal counsel select the firm that knows the issues ...

Theodosia A. Tamborlane, P.C.



THEODOSIA A. TAMBORLANE, P.C.

COUNSELORS AT LAW

1044 ROUTE 22 WEST, MOUNTAINSIDE, NEW JERSEY 07092

908-789-7977

Member, American Medical Association Doctors Advisory Network

Charter Member, American Association of Physician-Hospital Organizations-Integrated Healthcare Delivery Systems

The magnetic brain: A treatment modality

Eric J. Lerner

Since the brain produces varying electrical fields and electric currents, it must produce varying magnetic fields, which always accompany electrical currents. Such magnetic fields can be used to probe more deeply into the brain, since the scalp and skull are essentially transparent to such fields, but severely distort the electrical fields measured by the electroencephalogram (EEG). The development of the extremely sensitive superconducting quantum interference device (SQUID) has enabled scientists to measure these very weak magnetic fields to produce magnetoencephalograms (MEG).

But if the brain externally produces magnetic fields that easily penetrate the skull, could artificial and natural magnetic fields produced externally influence the brain? For a long time, evidence has been accumulating that such influences do occur, and in the past decade small groups of researchers have been using extremely weak fields, comparable to those that the

brain itself produces with therapeutic effect in diseases such as epilepsy, Parkinson's disease, and multiple sclerosis.

Magnetic field effects. It has been known for some time that strong static magnetic fields can affect the brain. In 1989, Klitzing demonstrated that the strong static magnetic fields used in MRI scanners—fields about ten thousand times stronger than that of the earth—increase the amplitude of the EEG. The earth's own field also seems to have a more subtle effect. During certain activities, such as fist clenching, overall EEG power was 25 percent less when 24 subjects were sitting in an east-west direction than when they were sitting in a north-south direction, although for some other activities the differences were negligible.

The brain's own magnetic fields are a few million times weaker than that of the earth and oscillate at the same frequencies as the electrical fields that produce the EEG—from a few Hz to 40 to 50 Hz, with peak power around 10 Hz. Yet some

researchers have found that even fields as weak as the brain's own, oscillating at the same frequencies, can affect the brain in measurable ways. This is not too startling, since it is well known that systems that naturally oscillate at certain frequencies readily respond to or resonate with external forces driven at the same frequency. Thus, for example, a radio circuit, tuned to the frequency of a transmitter easily responds to electromagnetic fields, which are about as weak as those produced by the brain (although at far higher frequencies).

At Democriton University of Thrace, researchers Anninos, Tsagas, and Derpapas studied epileptic patients with MEG records in the late 1980s. They found that the time-averaged magnetic fields produced by epileptic patients were far more uneven over the skull than were those for normal subjects. Especially in the frequency range from 2 to 7 Hz, epileptics exhibited sharp peaks of magnetic activity centered, presumably,

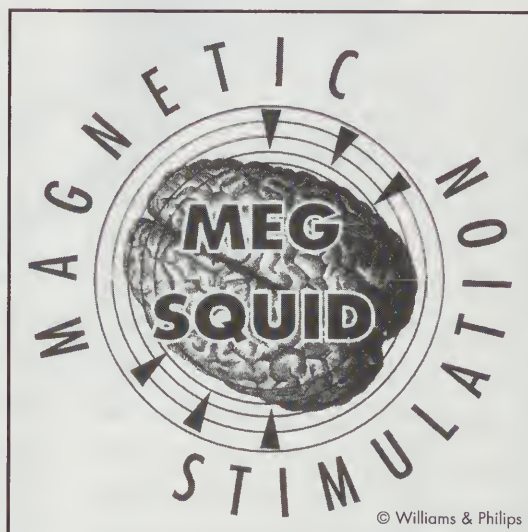
over the source of the epileptic activity. Anninos wondered if the magnetic fields, rather than being purely symptomatic of the epileptic conditions, could in some way be partly causative. His group decided to try to cancel out the concentrated fields with externally produced oscillating fields. Whenever identical wave forms, either electro-

magnetic or sound, which are directly out of phase, interact, they can cancel out each other. So the Greek researchers designed an electrical device, consisting of a number of magnetic coils, that could reproduce the magnetic field produced by the brain, but be directly out of phase with the original field, and thus generate a cancellation of fields over

the area of most intense activity. After treatment with this magnetic device for only a few minutes, epileptic patients' concentrated peaks of magnetic activity disappeared or were dramatically reduced in intensity for several days after treatment. More dramatically, in over 100 patients, there was significant improvement in the frequency of seizures ranging from substantial improvement to almost complete elimination. This improvement was maintained if the patient

self-treated with the portable device for a few minutes each day. Placebo treatment in which the device was not turned on (and the patient was not aware of this) produced no change in MEG or symptoms.

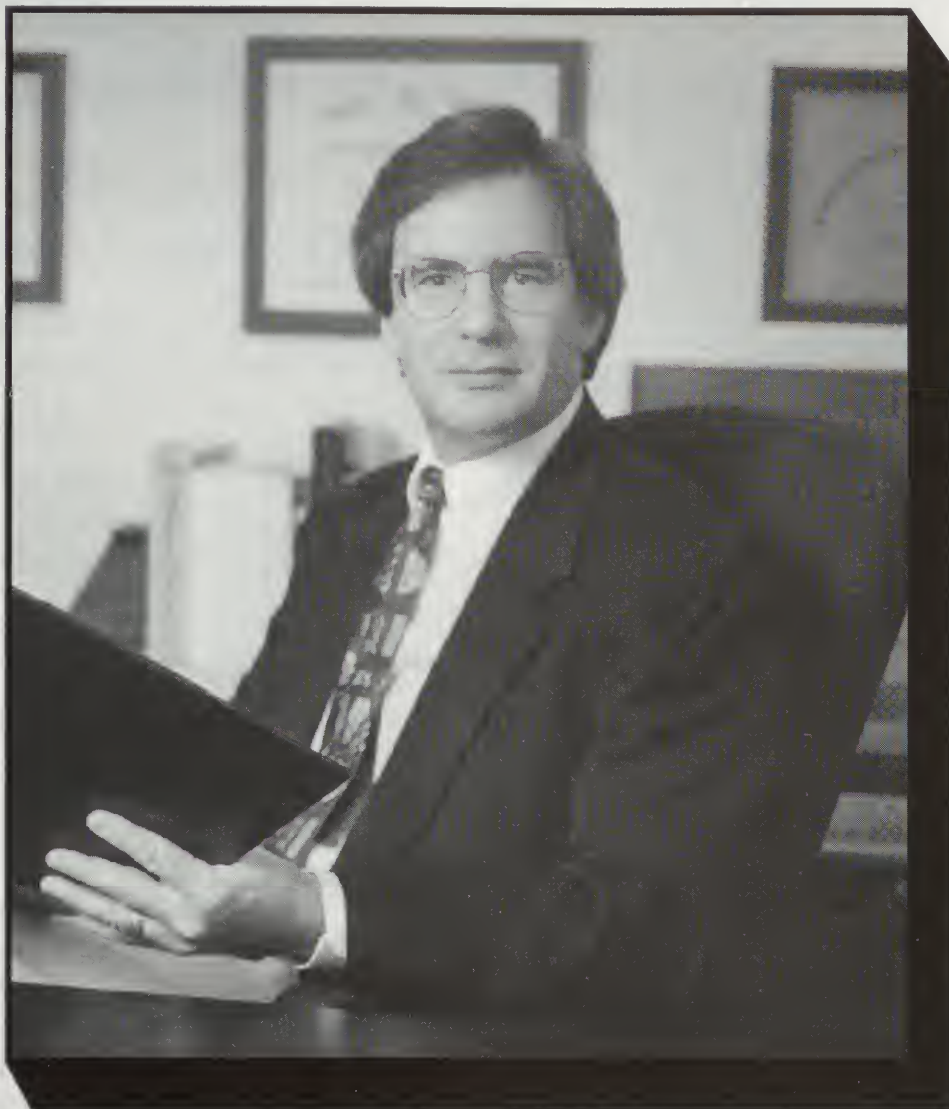
Magnetic stimulation versus Parkinson's disease. Inspired by the work in Greece, other



researchers have sought with some success to apply weak oscillating magnetic fields to other diseases. Sandyk, a Long Island neurologist, began testing magnetic stimulation on Parkinson's and MS patients. "I was impressed by their work with epilepsy, but since this was not my main field of interest I wondered if similar techniques could be used in Parkinson's," Sandyk explains. He employs a somewhat different technique, using sine waves, square waves,

or triangular waves at a single frequency, generally around 7 Hz, but tailored to the specific patient. "All patients are helped by the treatment," Sandyk says, "but some are helped more than others." Typical responses in Parkinson's patients include improvements in writing and drawing tests, reduction or elimination of visual neglect (ignoring one half of the visual field), and improvements in the ability to walk. Sandyk believes that the main mechanism of action in these cases is through magnetic stimulation of the pineal gland.

The research in stimulation with each magnetic field still is limited to only a few groups worldwide. "We have not been so much attacked by others in the field as we have been ignored," Sandyk says. Some scientists remain skeptical that such small fields can have any effect at all, although there are many examples of resonant systems that respond to very small external signals near the systems' resonant frequency. But the promising clinical results seem to indicate that magnetic stimulation is a new treatment modality worth investigating.



Stuart M. Hochron, M.D., Esq.

Physician Legal Representation

- Group Practice Formation
- Physician Litigation
- Federal Regulation
- Board of Medical Examiners

Practicing Physician, Twenty Years

Clinical Professor, UMDNJ-RWJMS

Research as Highlighted on CNN

AMA Physician Referral Service

Partner, Richmond, Hochron & Burns



phone: (732) 821-0200 fax: (732) 422-9444 e-mail: MDLAWSMH@aol.com

209 North Center Drive North Brunswick, New Jersey 08902

editorial guidelines

Editorial Guidelines

The principal aim in the preparation of a contribution should be relevance to health care and to the education of patients and health care professionals. The contents of each issue include an important health care development; an indepth interview highlighting a health care newsmaker; an update on a key public health issue; a peer-reviewed clinical report; brief highlights of the latest events and findings in the health care industry; and a monthly forum for readers. Proposals for special submissions will be considered on an individual basis. Letters to the editor are welcome and will be edited and published as space permits. Notices of events, programs, and meetings are encouraged.

Copyright

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or separate statement accompanying material offered to *New Jersey MEDICINE* must contain the following language, and must be signed by all authors.

"In consideration of *New Jersey MEDICINE* taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey in the event that such work is published in *New Jersey MEDICINE*."

Publication Policy

New Jersey MEDICINE will review original unpublished materials on topics relevant to health care professionals in New Jersey. All submissions are subject to peer review and are edited to conform to the style of *New Jersey MEDICINE*. Receipt of materials will be acknowledged. Final decision is reserved for the editor. No direct contact between the reviewers

and the authors will be permitted. Upon acceptance authors will have the opportunity to review edited material. All communications should be sent to *New Jersey MEDICINE*, Two Princess Road, Lawrenceville, NJ 08648.

Specifications

Materials compatible with Microsoft Word 6.0 for Windows should be submitted on diskette (3 1/2 inch), and should be accompanied by a printed copy of the material, a cover letter identifying the submission, and a copyright form.

The title page should include the full names, degrees, and affiliations of all authors, and the name and address of the author to whom correspondence should be sent.

The author(s) should submit a 30-word abstract to be used at the beginning of the article. Reference should not exceed 35 citations and should be cited consecutively by superscripted numbers at the end of the sentence. The style of *New Jersey MEDICINE* is that of *Index Medicus*: 1. Goldwyn RM. Subcutaneous mastectomy. *NJ MED* 74:1050-1052, 1977. Tables and graphs should be presented at the end of the article. Illustrations should be of professional quality, black and white glossy prints. The name of the author, figure number, and top of the figure should be clearly marked on the back of each illustration. When photographs of patients are used the subjects should not be identifiable or publication permission signed by the subject or responsible person must be included. Materials taken from other publications must give credit to the original source. Generic names should be used with proprietary names indicated parenthetically with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol.

NJM

PHYSICIANS NEED TO BE MEMBERS OF ORGANIZED MEDICINE

Joseph F. Fennelly, MD

Physicians must remain active in organized medicine. We need to be a part of the solution, not the problem.

Physicians are becoming increasingly disillusioned with professional organizations that have traditionally represented their values and goals. Physicians in New Jersey and throughout America are rejecting membership in their organized medical societies.

The very recent Sunbeam controversy has added to this attitude. The remarkable actions and challenge of the Medical Society of New Jersey (MSNJ) as well as the response of the community of the American Medical Association (AMA) calling for complete airing of the Sunbeam issue, would argue that more doctors maintain, rejoin, or become members of organized medicine.

The actions that MSNJ and the AMA took regarding the Sunbeam endorsement demonstrate a commitment to organized medicine's highest principles. It also shows that a genuinely democratic organization can find within itself the character and leadership essential for change.

At the October 1997 MSNJ Board of Trustees meeting, a letter was read by Louis Keeler, MD, MSNJ past-president, calling for the resignation of the AMA executive vice-president and chair of the AMA Board of Trustees. While no one expected that this issue would be given only cursory attention, the overwhelming response sounded like the "shot heard round the world."

As each individual spoke, what developed was the expression of a method to resolve the many months of frustration relating to the Sunbeam issue and its broad implications for all physicians.

With deep conviction, MSNJ executive director, Vincent A. Maressa, presented a comprehensive critique of possible reasons why conflicts of interests developed in the AMA. He underscored the fact that when the AMA executive vice-president is chosen from within the ranks of the Board of Trustees, there is the possibility for mischief. Bureaucracies tend to maintain themselves.

At this point, conversation turned to authentic rhetoric—discourse that represents the essence or the soul of the matter. A collective conscience was speaking: issues were about each physician, each state, and one national organization representing the physicians of America. It was about values, goals, and what it means to be a member of the "moral community" of medicine.

The room became electrified. We, the physicians of New Jersey, would go the AMA and speak as the conscience of physicians of America. We would inform, create, and recreate the values of the AMA.

The chair of the New Jersey Delegation to the AMA expressed concern that if other states did not share New Jersey's commitment our Delegation would be left hanging and would lose credibility. Many reassured him that this was unlikely—despite a history to the contrary. The chair dedicated a substantial amount of time to networking both locally and throughout the country. He contacted states that were more likely to take the initiative for change. The media expressed interest; a front-page article in *The Star-Ledger* relayed some of the details. The Delegation crafted a late resolution that was devoid of ambiguity regarding the AMA leadership.

The Organized Medical Staff Section (OMSS) met for three days before the opening of the AMA House of Delegates to develop consensus, educate, and network. Conversations turned to shared interests. This was one meeting that was defined not by personal interest, but by a common cause: the survival of and re-establishment of the integrity and the trust in the AMA. By virtue of common interests, I spent time with some physicians who were deeply committed to uncovering as many facts as possible in the case. One physician spent hundreds of hours studying the archives of the AMA for the last 50 years. She uncovered relevant material details. She spoke openly to these issues. This same group contacted Arnold Relman, MD, and Dr. Edmund Pellegrino.

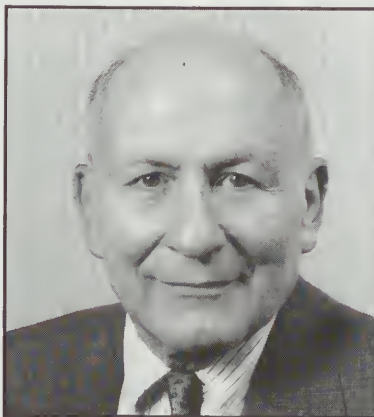
A moral community was in action. The die was cast.

As the intentions of the New Jersey Delegation were discussed from the floor, it was no accident that Relman and George Lundberg, MD, were the first and second speakers. Relman emphasized what New Jersey knew and noted that the Sunbeam issue was the biggest crisis the AMA ever faced. Lundberg, senior editor of *The Journal of the American Medical Association*, spoke elegantly and with deep concern and conviction about the AMA's responsibility. Both physicians stressed that swift and open action be taken to make the necessary moral compass adjustment; loud applause followed their statements.

The MSNJ president, as an AMA delegate, suggested that a "Warren-like" commission be formed and that this group be responsible to the AMA House of Delegates. And, such a committee has been formed. MSNJ's Irving Ratner, MD, is one of the seven members of this ad hoc committee studying the problem.

What significance does this have for the individual physician? When I needed help from state and

national medical society members, it was there. With the Karen Ann Quinlan case, our good and departed friend, James Todd, MD, from New Jersey and former AMA executive vice-president (the drafter of the new AMA *Code of Medical Ethics*) was there for personal and professional support. When we needed help defining feeding tubes as medical intervention, Nancy Dickey, MD, then chair of the Council on Ethical and Judicial Issues for the AMA, was there to define and reinforce our position. With physician assisted suicide, MSNJ took the time and effort to prepare an *amicus* brief and involved the AMA.



Joseph F. Fennelly, MD

Organizations are living systems. They work best when they are not too hierarchical. The sharing of decision making to create and recreate common goals is necessary.

MSNJ and the AMA are working to get the AMA back in order and to confront evils that are threatening the trust and commitment of the doctor/patient relationship and the survival of the profession of medicine as a moral community.

It is the obligation of every New Jersey and American physician to assume and maintain their part of the obligation. The opposite of caring is not "not caring," it is indifference. We either are part of the problem or part of the solution. As we argue, we must remain active in our medical societies. By not doing so, we simply throw the burden on the few who dedicate themselves to leadership. William Safire observed that optimists are the ultimate realists. The reason that optimism makes the difference is that human beings and all our creations are perfectible.

Dr. Fennelly is chair, MSNJ Committee on Biomedical Ethics, and a member of the AMA Organized Medical Staff Section. He is affiliated with Morristown Memorial Hospital.



Institute for
WOMEN'S HEALTH



NATIONAL CENTERS OF
EXCELLENCE
IN WOMEN'S HEALTH

present

**A WOMEN'S HEALTH SERIES
FOR PRIMARY CARE PROVIDERS**

for Family Practitioners, General Practitioners, Internists,
Obstetricians and Gynecologists, Physician Assistants,
Nurse Practitioners, Nurse Midwives, Residents, Fellows,
and other interested health care professionals.

Friday, March 13, 1998

Hormone Replacement Therapy:

Opportunities for Prevention in Primary Care
1:30 - 5:30 p.m.

Saturday, April 25, 1998

Pelvic Floor Disorders:

*Successful Treatment Through a Primary Care Provider
and a Multidisciplinary Team*
8:30 a.m. - 1:30 p.m.

Saturday, May 2, 1998

Breast Disease Management:

Issues for the Primary Care Physician
8:30 a.m. - 1:00 p.m.

Location

Education and Research Facility
MCP♦Hahnemann School of Medicine
2900 Queen Lane, Philadelphia, PA
ample free parking

4.0 Category 1 AMA, Category 2A AOA, and Prescribed AAFP credits available

Co-sponsored by



ALLEGHENYSM
UNIVERSITY OF
THE HEALTH SCIENCES

ALLEGHENY UNIVERSITY HOSPITAL
FOR WOMEN AT CITY AVENUE

MCP♦Hahnemann School of Medicine
Office of Continuing Medical Education

For additional information or to request a brochure - Call 215-762-8263

MARCH/APRIL '98

Medical Grand Rounds

March 11, 18, and 25, 1998
VA Medical Center, East Orange
973/982-6170

Interhospital Endocrine Rounds

March 11, 18, and 25, 1998
University Hospital, Newark
973/982-6170

Head and Neck Oncology

March 11, 1998
The Manor, West Orange
AMNJ, 609/275-1911

Vascular Society Meeting

March 11, 1998
Cooper Hospital, Camden
AMNJ, 609/275-1911

General Internal Medicine

March 17, 1998
UMDNJ, New Brunswick
732/235-7430

Peritoneal Dialysis

March 17, 1998
Overlook Hospital, Summit
AMNJ, 609/275-1911

Imaging of Primary Small Bowel Pathology

March 18, 1998
Cooper Hospital, Camden
609/342-2383

Pregnant Women with HIV/AIDS

March 18, 1998
Union Hospital, Union
AMNJ, 609/275-1911

Radiological Society

March 19, 1998
UMDNJ-Robert Wood Johnson Medical
School, New Brunswick
973/533-5803

Society of Anesthesiologists

March 20-22, 1998
Trump Plaza Hotel & Casino
609/275-0083

TB Management of HIV-infected Patient

March 24, 1998
South Jersey Hospital, Elmer
AMNJ, 609/275-1911

Academy of Otolaryngology

March 25, 1998
PNC Arts Center Holmdel
AMNJ, 609/275-1911

Radiology Lecture

March 26, 1998
St. Barnabas Medical Center, Livingston
973/533-5805

Semmelweis-Waters Conf.

March 27-29, 1998
Trump Plaza, Atlantic City
327/235-7430

Clinical Infectious Disease

March 27-29, 1998
The Plaza Hotel, New York
201/385-8080

Endocrinology Visiting Professor Lecture

April 1, 1998
VA Medical Center, East Orange
973/676-1000 x1311

Interhospital Endocrine Rounds

April 1, 8, 15, 22, and 29, 1998
University Hospital, Newark
973/982-6170

Medical Grand Rounds

April 1, 8, 15, 22, and 29, 1998
VA Medical Center,
East Orange
973/982-6170

Dermatological Soc. Mtg.

April 14, 1998
Schering, Kenilworth
AMNJ, 609/275-1911

Potpourri of Interesting Chest Cases

April 15, 1998
Cooper Hospital, Camden
609/342-2383

Pediatric HIV Infection

April 15, 1998
Union Hospital, Union
AMNJ, 609/275-1911

Pediatric HIV Infection

April 15, 1998
Warren Hospital, Philipsburg
AMNJ, 609/275-1911

Radiol. Soc./Ultrasound Inst.

April 16, 1998
St. Barnabas Medical Center, Livingston
973/533-5822

General Internal Medicine

April 21, 1998
UMDNJ, New Brunswick
732/235-7430

New Clinical Trials in Transplantation

April 21, 1998
Overlook Hospital, Summit
AMNJ, 609/275-1911

Orthopaedic Society Annual Meeting

April 21-26, 1998
Palm Springs, CA
AMNJ, 609/275-1911

Pediatric HIV Infection

April 21, 1998
South Jersey Hospital,
Elmer
AMNJ, 609/275-1911

The Original

**PHILADELPHIA
BOARD REVIEW
COURSE IN
CARDIOVASCULAR
DISEASESSM**

**Tuesday-Sunday
October 13-18, 1998**

Sponsored Annually by



co-sponsored by
Council on Clinical Cardiology of the



**Location: Wyndham Franklin Plaza Hotel
Philadelphia, PA**

Why Should You Attend This Board Review Course?

The Original Philadelphia Cardiovascular Board Review...offered since 1983

Over 90% pass rate!

*More days, more hours, more lectures, more topics
than other courses*

Geared exclusively for taking the Boards; contains all the required subjects, no research or esoteric topics

Most Comprehensive Course Syllabus

Fee includes continental breakfasts, luncheons, breaks, exhibits, and evening sessions

Low hotel rates - close to great restaurants, shopping, theaters, museums, and sports venues

Course faculty of nationally-known scholars

This program is designed to provide the physician with an intensive in-depth review of the clinical manifestations, pathophysiology, and treatment of cardiovascular diseases.

Allegheny University of the Health Sciences, MCP•Hahnemann School of Medicine is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

Allegheny University of the Health Sciences, MCP•Hahnemann School of Medicine designates this educational activity for a maximum of 50.0 hours in category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

This program is eligible for 50.0 credit hours in category 2A of the American Osteopathic Association.

All faculty participating in continuing medical education programs sponsored by Allegheny University of the Health Sciences, MCP•Hahnemann School of Medicine are expected to disclose to the audience any real or apparent conflict(s) of interest related to the content of their presentation.

Call 215-762-8264 for information or a brochure.

June 8-12th, 1998

Update Your Medicine twenty-fourth annual practical CME course with lectures, workshops, and Meet-the-Professor luncheons. Sponsored by Cornell University Medical College in New York City and the Association of Practicing Physicians of The New York Hospital. 37.25 Category 1 AMA-PRA credit. Additional 11½ credits available for Hands-on Workshops. This program has also been reviewed and is acceptable for 37.25 prescribed hours by the American Academy of Family Physicians. Information: Lila A. Wallis, MD, Director and Debora A. Laan, Coordinator, 445 East 69th Street, Olin-Room 328, New York, NY 10021. Telephone: 212-746-4752.

Specializing in the Business of Health Care

Physician Practice Assessment/Contract Negotiations
Fee Schedule & Super Bill Analysis/New Practice Set-Up
Coding Issues/Risk Management

Call Evelyn Gross, CMM, CPC
(201) 261-4030

HUNTER HEALTHCARE SERVICES

Division of RD Hunter & Company LLP
Paramus, NJ New York City

INTERNATIONAL COLLEGE OF ACUPUNCTURE & ELECTRO-THERAPEUTICS

*(Permanently Chartered by the University of the State of New York,
State Education Department)*

1998 Seminars & Workshops & 14th Int. Symposium

ACUPUNCTURE & ELECTRO-THERAPEUTICS in Clinical Practice

25 credit hours can be earned by attending
one three-day weekend (Friday-Sunday) session **9 am-7 pm**

March 13-15, 1998 Holiday Inn, Manhattan
May 15-17, 1998 440 W. 57th St, NYC between 9 & 10 Ave.
June 19-21, 1998 Hotel 212-581-8100 during meetings

14th Annual International Symposium, Oct. 22-25, 1998

the School of Int'l Affairs, Columbia University

In addition to holding 7-8 seminars & workshops per year, the International College of Acupuncture & Electro-Therapeutics organizes an Annual International Symposium every October at the School of International Affairs, Columbia University, NYC and publishes **Acupuncture & Electro-Therapeutics Research**, **The International Journal** quarterly, through Cognizant Communications and is listed by 15 major international indexing periodicals (**Index Medicus**, **Current Content**, **Excerpta Medica**, etc.), is recognized as a major leading journal in the field. The most prestigious and internationally recognized, "Fellow of the International College" (F.I.C.A.E.) will be awarded to members of the College who present a minimum of 2 original research papers during the annual International Symposium and publish them in the official journal, or who have made significant contributions in the field.

These seminars & workshops train physicians and dentists in the latest theories and techniques of manual & electro-acupuncture, TENS & simple non-invasive diagnostic methods (including cardiovascular, neuro-muscular, central nervous systems & Bi-Digital O-Ring Test).

For information, contact Dr. Y. Omura, MD, ScD, FICAE, 800 Riverside Drive (8-I), NY, NY 10032; 212-781-6262, Fax 212-923-2279 or Dr. Richard Simon, PhD, 212-662-7022 or Ms. Sandra Beckman, MA, 212-679-8986. All ICAE meetings are accredited by the New York State Boards for Medicine and Dentistry toward the 300 accredited hour requirement for the Acupuncture Certificate in New York State. Also eligible for AMA/CME Category I credit. MSSNY designates this CME activity for AMA/CME Category I credits toward Physician Recognition Award.

APRIL-JUNE '98

Pediatric Trauma Conference

April 21, 1998
RWJ Med School, New Brunswick
732/235-7430

Urology Society Awards Dinner

April 22, 1998
The Manor, West Orange
AMNJ, 609/275-1911

Radiology Visiting Professor Lecture

April 23, 1998
St. Barnabas Medical Center, Livingston
973/533-5803

Medical Society of New Jersey Annual Meeting

April 28-May 2, 1998
Trump Taj Mahal Casino, Atlantic City
609/896-1766

International Conference on Physician Health

April 29-May 2, 1998
Location to be announced
312/464-5073

Eastern Vascular Society

May 1-3, 1998
Newport Marriott Hotel, Newport, RI
AMNJ, 609/275-1911

Ambulatory Ob-Gyn and Reproductive Serv.

May 1-2, 1998
RWJ Med School, New Brunswick
732/235-7430

Endocrinology Visiting Professor Lecture

May 6, 1998
VA Medical Center, East Orange
973/676-1000 x1311

Medical Grand Rounds

May 6, 13, 20, and 27, 1998
VA Medical Center, East Orange
973/982-6170

Interhospital Endocrine Rounds

May 6, 13, 20, and 27, 1998
University Hospital, Newark
973/982-6170

Dermatological Society Meeting

May 12, 1998
Location to be announced
AMNJ, 609/275-1911

Head and Neck Oncology

May 14, 1998
The Manor, West Orange
AMNJ, 609/275-1911

Pathology of Hemodialysis Access Dysfunction

May 19, 1998
Overlook Hospital, Summit
AMNJ, 609/275-1911

General Internal Medicine

May 19, 1998
UMDNJ, New Brunswick
732/235-7430

Society of Anesthesiologists Meeting

May 19, 1998
Forsgate Country Club, Jamesburg
609/275-0083

Radiological Society Meeting

May 21, 1998
RWJ Med School, New Brunswick
732/235-7721

Opportunistic Infections

May 22, 1998
Newcomb Medical Center, Vineland
AMNJ, 609/275-1911

Radiology Visiting Professor Lecture

May 28, 1998
St. Barnabas Medical Center, Livingston
973/533-5803

Pediatric Society Meeting

June 3, 1998
Woodbridge Hilton
AMNJ, 609/275-1911

Gastroenterological/ Gastrointestinal Endoscopy

June 3, 1998
The Manor, West Orange
AMNJ, 609/275-1911

Ob/Gyn Society Annual Meeting

June 5-7, 1998
Trump Plaza Hotel, Atlantic City
AMNJ, 609/275-1911

Oncology Soc. Annual Meet.

June 10, 1998
Hyatt Regency, New Brunswick
AMNJ, 609/275-1911

12th World AIDS Conference

June 28-July 3, 1998
Geneva, Switzerland

MSNJ Annual Meeting

April 28-May 2, 1998

Housing application available
at www.msnj.org

HOUSING APPLICATION

232ND ANNUAL MEETING
MEDICAL SOCIETY OF NEW JERSEY

APRIL 28-MAY 2, 1998

TRUMP TAJ MAHAL CASINO/RESORT

1000 BOARDWALK AT VIRGINIA AVENUE, ATLANTIC CITY, NJ 08401

RESERVATION DEPARTMENT 1-800-825-8888

(Please Print)

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Sharing With _____

Date of Arrival _____ Time _____

Date of Departure _____ Time _____

A one-night deposit (equivalent to room rate) is required with all reservation requests. Please send check or money order payable to the **TRUMP TAJ MAHAL CASINO/RESORT** or complete the following:

Card # _____ Type _____ Exp. Date _____

SCHEDULE OF RATES SUBJECT TO 12% TAX, PLUS \$2 PER ROOM, PER NIGHT

() SINGLE \$118.00 () DOUBLE \$118.00 EXTRA PERSON \$25.00

Reservations must be received prior to MARCH 30, 1998.

() One-Bedroom Suite \$275.00 per day () One-Bedroom Hospitality Suite \$350.00 per day

Check-out time is 12 Noon. Rooms may not be available for check-in until after 4 p.m. Check-in time on Sundays is 6 p.m. FORTY-EIGHT (48) HOURS NOTICE OF CANCELLATION is required for a full refund. PARKING: There is a state-imposed \$2.00 minimum charge per 24-hour period for each motor vehicle parking on the premises.

() Check if Official Delegate _____ County _____

PLEASE NOTE: Current state sales tax is 3% and occupancy tax is 9%, and room usage fee is \$2.00 per room, per night. These taxes are subject to change, without notice.

The proceeds from the fees collected shall be paid into a special fund which will be established and held by the Atlantic City Convention Center Authority. Amounts in the special fund shall be expended by the Convention Center Authority solely for the purposes of promoting tourism, conventions, resorts and casino gaming.

MAIL THIS APPLICATION TO: Reservations
Trump Taj Mahal Casino/Resort
1000 Boardwalk at Virginia Avenue
Atlantic City, NJ 08401

Housing Application online at www.msnj.org

AD RATES

Classified Section

\$ 1.00 per word

\$45.00 minimum

Confidential Box # = 5 words

Display ad in Classified Section

\$60.00 first 1" per column

\$30.00 each additional 1/2" per column

CLASSIFIED AD PLACEMENT

MAIL—NEW JERSEY MEDICINE

370 Morris Avenue

Trenton, NJ 08611

FAX—609-393-3759

DEADLINE—10th of month preceding month of issue

QUESTIONS—Call 609-393-7196

WORDING OF AD CANNOT BE TAKEN VERBALLY BY PHONE

PLEASE WRITE OR TYPE CAREFULLY. AD WILL BE PLACED EXACTLY AS RECEIVED.

BOLD HEADING (optional)
(limit, 20 characters per line)

Requested Category

Body copy
(35 characters per line)

Classified Section

Number of Words

Minimum \$45 \$ _____

Member Physician

Discount— $33\frac{1}{3}\%$ (\$ _____)

Per Issue \$_____

× Number of Issues

AMOUNT DUE \$ _____

Display Ad in Classified Section

1st Inch = \$60.00 \$ _____

Add 1 1/2" x \$30.00 \$ _____

Total \$ _____

Member Physician
Discount—33⅓% (\$ _____)

PER ISSUE \$ _____

× NUMBER OF ISSUES

AMOUNT DUE \$ _____

ALL CLASSIFIED ADS MUST BE PRE-PAID

Please make check payable to the
Medical Society of New Jersey

**THE MEDICAL SOCIETY OF NEW JERSEY
CLASSIFIED ADVERTISEMENT INSERTION REQUEST**

RATES

(Placement in New Jersey *MEDICINE* OR on WEB Site)

	<u>New Jersey <i>MEDICINE</i></u>	<u>http://www.msnj.org WEB Site</u>
Month—Non-Members		
Minimum 45 words	\$ 45.00	
Each word		
45 words	\$ 1.00	
Month—Members		
Minimum 45 words	\$ 30.00	
Each word		
45 words	\$ 1.00	
Month—		
Minimum 45 words		\$ 45.00
Each word		
45 words		\$ 1.00

(Placement in New Jersey *MEDICINE* AND on WEB Site)

	<u>New Jersey <i>MEDICINE</i></u>	<u>http://www.msnj.org WEB Site</u>
Month—Non-Members		
Minimum 45 words	\$ 45.00	\$ 36.00
Each word		
45 words	\$ 1.00	\$.80
Month—Members		
Minimum 45 words	\$ 30.00	\$ 36.00
Each word		
45 words	\$ 1.00	\$.80

PREPARE YOUR COPY ON A SEPARATE PAGE AND ATTACH TO THIS ORDER FORM

INSERTION AUTHORIZATION

MSNJ Member? Yes _____ No _____
Telephone Number _____
Fax Number _____
State _____ ZIP _____
New Jersey *MEDICINE* Issues _____
Number of 30 Day Insertions _____

New Jersey <i>MEDICINE</i>		New Jersey <i>MEDICINE</i>	
Member		Member	
Minimum 45 Words	\$ _____ 45.00	Minimum 45 Words	\$ _____ 30.00
+ Each Add'l Word @\$1.00	\$ _____	+ Each Add'l Word @\$1.00	\$ _____
Per Issue	\$ _____	Per Issue	\$ _____
X Number of Issues		X Number of Issues	
AMOUNT DUE	\$ _____	AMOUNT DUE	\$ _____
WEB SITE		MSNJ WEB SITE WITH NEW JERSEY <i>Medicine</i> Placement	
Non-Member or Member		Non-Member or Member	
Minimum 45 Words	\$ _____ 45.00	Minimum 45 Words	\$ _____ 36.00
+ Each Add'l Word @\$1.00	\$ _____	+ Each Add'l Word @\$.80	\$ _____
Per Month	\$ _____	Per Month	\$ _____
X Number of Months		X Number of Months	
AMOUNT DUE	\$ _____	AMOUNT DUE	\$ _____

TOTAL DUE \$ _____ ALL CLASSIFIED ADS MUST BE PRE-PAID

Please make check payable to "Medical Society of New Jersey"

Mail to: Classified Ad Department
370 Morris Avenue
Trenton, NJ 08611

Tel: 609-393-7196
Fax: 609-393-3759

CLASSIFIED ADS

100 OPENINGS PHYSICIANS (MULTIPLE SPECIALTY LISTINGS)

THE PODELL MEDICAL CENTER

New Providence Holistic Health Center: Seeking collaboration from well-trained physicians from all specialties. Especially Women's Health: also Pediatricians or Family Physicians to help develop program for A.D.D. children. Contact Dr. Podell 908-464-3800 or fax 908-464-3078.

110 OPENINGS PHYSICIANS

DERMATOLOGY PRACTICE OPEN OPPORTUNITY

Thriving well-established practice on Jersey Shore seeking energetic individual to assume practice. Can also accommodate P/T work, 1-2 days/wk; terms negotiable. Confidential Box #137, c/o NEW JERSEY MEDICINE, 370 Morris Avenue, Trenton, NJ 08611.

FAMILY PRACTICE MORRIS COUNTY

Excellent opportunity for a physician to join an established Family Practice in Morris Plains, Morris County, New Jersey. Salary commensurate with experience. Will introduce. Terms available. Please fax resume ATTN: FAP (516) 665-0555.

BC/BE PEDIATRICIAN CAPE MAY COUNTY

To join pediatric group practice. Competitive salary. Early partnership. Please send CV to Cape Pediatric Associates, P.A., 301 Dennisville Rd., Cape May Court House, NJ 08210.

130 OPPORTUNITY WANTED

FAMILY PRACTICE

Board Certified Family Practitioner looking for F/PT Practice Opportunity. Prefer Camden or Burlington Counties but willing to relocate. I am a hard working and dedicated Physician. Write 31A W. 2nd Street, Florence, NJ 08518 or call 609-499-8678.

170 OPENINGS—STAFF

MANAGER/ADMINISTRATOR ATLANTIC COUNTY

Large, multi-location OB/Gyn practice in Atlantic County seeks individual with proven administrative and management skills. Responsible for overall operations including financial, utilization, data processing, billing and claims functions. Call Mr. Rubin (609) 652-1453, Ext. 12.

200 PRACTICE FOR SALE

ORTHOPAEDIC PRACTICE

Active Orthopaedic practice for sale—NE NJ (Suburban NYC Area)—in 1998. Differed financial incentives available for new Orthopaedist. Write: POB 4724, Clifton, NJ 07015.

300 OFFICE RENTALS AND LEASES

EDISON

Office Space—Edison Medi-Plex Building opposite J.F.K. Hosp. Fully equipped, turn key. Rent: day, half day, night. (732) 494-6300.

HILLSBORO

Hillsboro Medical Office—1,500 sq. ft. \$1,000/mo. Busy location. Active practices in building. Ideal for new or 2nd practice. Call Dr. Wolinsky 212-476-7789 days or 215-860-8491 eves.

MILLBURN

Medical Arts Building, Millburn Avenue. Fully equipped, turn key. Rent day, 1/2 day, night. Call 973-376-8670.

MOORESTOWN

Several offices available in Medical Complex. Various sizes. Excellent location. Stanley R. Lane, MD (609) 235-2651.

TOMS RIVER

Medical office for lease—1,141 square feet on first floor in established medical office building. Private basement for storage included at no extra rent. Handicap accessible. Ample parking. Good location with excellent exposure. Call (732) 929-1616.

305 WANTED—OFFICES TO SHARE

ESSEX, UNION, MORRIS, PASSAIC COUNTIES

Pediatric Nutritionist/Adult and Child Weight Management Specialist, R.D., M.P.H., C.D.E., seeks small office space rental or fee-for-service with multispecialty/pediatric/internal medicine practice; most major managed care insurances accepted. Essex, Union, Morris, Passaic counties. Call: 973-275-0363.

310 OFFICES TO SHARE

FORT LEE (BERGEN COUNTY)

Established 15 yr. Chiropractic Practice—Interested in sharing a 1600 Sq. Ft. spacious, modern office with 5 treatment rooms. Located in a residential area of Fort Lee—5 minutes from G.W.B. Turnkey Operation. (201) 886-8755.

SOMERVILLE

Medical Office to share. Modern professional office building two blocks from Somerset Medical Center. Hours to suit. Ideal for new practitioner or expansion into area. Ample parking. Handicap accessible. Four treatment rooms including minor operator. Large waiting room and business area. Call 908-231-1114.

325 MEDICAL BUILDING SALE OR LEASE

LAWRENCEVILLE

2300 sq. ft. Condominium Professional Close to Rt. 1 corridor. Four exam room consultation rooms. Large work areas chair accessible bathroom. Two lab Lounge, storage space built-in. Private entrance in rear. Purchase or Lease daytime between 9:00 a.m. and 3:00 p.m. 609-896-0242.

340 REAL ESTATE HOME/OFFICE

CLIFFWOOD

Close to three hospitals. One reception Three examining rooms. One consultation room. One billing room. One file room. One reception room. One large bathroom. Util Ramp access for wheel chair. Private entrance in rear. Parking lot. Completely fenced acre property. 732-566-0880 office 9 am-5:00 pm.

ELMWOOD PARK

ELMWOOD PARK HOME/OFFICE FOR SALE (available 6/1/98). Well kept home/office on main road in Elmwood Park. Ground floor is handicap accessible with 4 car garage. Office includes waiting room, reception area, Doctor's office, bathroom and 6 treatment rooms. Home includes Living Rm., Dining Rm., Family Rm., 5 Bed Rms., 3 Full Bathrooms, Laundry Rm., Storage. \$280,000. 201-796-5273 and leave message for information and floor plan.

MENDHAM BORO, NJ

Traditional colonial w/attached Dr. office for Medical Profession alt guest suite. Kitchen 12/97, fireplace in living rm, 4 bath. \$424,000 (MN-3199) Call 973-581-1111 Weichert Realtors.

MERCER COUNTY

Free standing office, approx. 2,000 sq. ft. exam rooms plus X-Ray room and Private Dr.'s office, waiting and reception 2 acres professionally landscaped with parking. Fully equipped and ready for \$300,000 for this turnkey opportunity. 609-890-9009.

415 MEDICAL BILLING

North American Financial Systems, Inc. cost medical billing company. Call Mike for information. (973) 535-0654.

420 FINANCIAL SERVICES

Attention Anesthesiologists!!! Don't be burdened with: Endless paper work, irreimbursement from HMOs and insurance companies. Obtaining information for billing constant follow-up with self-pay and co-pay. Call: Client Contact Company 1 (800) 644-1114. E-mail MedManCo @AOL.com. Fax inquiry (800) 473-1184. A Full Service Billing and Collection Company.

EMERGENCY PHYSICIANS

Emergency Physician Associates, a Team

Health affiliate, is seeking quality
ED physicians for a variety of practice
opportunities in NJ, PA, MD, NC and NY.

We offer physicians competitive
compensation, flexible schedules, malpractice
insurance, a variety of practice settings,
and supportive Medical Directors.

Interested candidates may call

1-800-848-EPA-1.



Organon Inc., of West Orange, NJ., is the United States operation of N.V. Organon, a renowned international ethical pharmaceutical company. As a business unit of Akzo Nobel, one of the world's leading companies in selected areas of chemical, coatings, health care products and fibers, we market a wide range of drugs - and lead ground breaking research programs - in the fields of reproductive medicine, anesthesiology, central nervous system disorders, thrombosis, and immunology.

Medical Monitor, Reproductive Medicine

In this role, you will function as a clinical expert in the Reproductive Medicine Group. This includes the management of safety issues, participating in the development of protocols and NDA submissions. Additionally, you will be responsible for the oversight of safety monitoring including training of other study members in the safety aspects of drug studies.

To qualify, you must be an MD (internal medicine, OB/GYN, family practice, preferred) with at least 1 year of clinical and/or pharmaceutical industry drug development experience. A commitment to clinical research and development is essential as are strong interpersonal and communication skills. Some travel may be required.

We offer a competitive salary and benefits package which includes a 401K plan and an on-site fitness center. To apply, send your resume and salary requirement, to: Organon Inc., Human Resources Dept. MDAPP, 375 Mt. Pleasant Ave, West Orange, NJ 07052. Due to the volume of responses received, we can respond only to those candidates of interest. Visit us on the Internet at www.organon.nl. An equal opportunity employer M/F/D/V.



Dedicated to the quality of life.

The Medical Manager[®]

Practice Management Software

A fully integrated practice management solution

Over 16 years' experience in providing
healthcare automation solutions

Provides an open system architecture
and flexibility for specialized needs

Designed for small group practices to large
Integrated Delivery Systems

Overwhelming national presence

*Learn more about how Medical Manager Corporation and
The Medical Manager system can meet your needs. Contact us
at 800.677.7784, 201.808.0088, or www.medicalmanager.com.*

**Medical
Manager**
Corporation

RTI, Inc. and Medix

Empowering the Industry Through Partnership

We know that practicing medicine is your primary concern.

The professionals at Healthcare Management Partners will take away the time-consuming administration and pressures of billing, collections, follow-up, office management, and system maintenance, so you can concentrate on doing what you do best - practicing medicine.

Contact Rosalie Fox or Robert Rahl at 609-734-0443 to find out more.

**Practice Assessments • Billing & Collection •
MIS Systems • Group Practice Formation •
Practice Management • Income Distribution**

**Endorsed Computerized Billing,
Accounts Receivable and
Information Management Company of the
Medical Society of New Jersey**



HEALTHCARE MANAGEMENT PARTNERS

PARTNERS IN PROFIT

200 Canal Pointe Boulevard • Princeton, NJ 08540-5998
609-734-0443 • FAX 609-243-9799

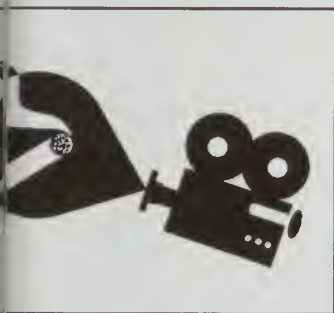
A Division of Health Information Consulting Services, Inc.

Continued from page 80

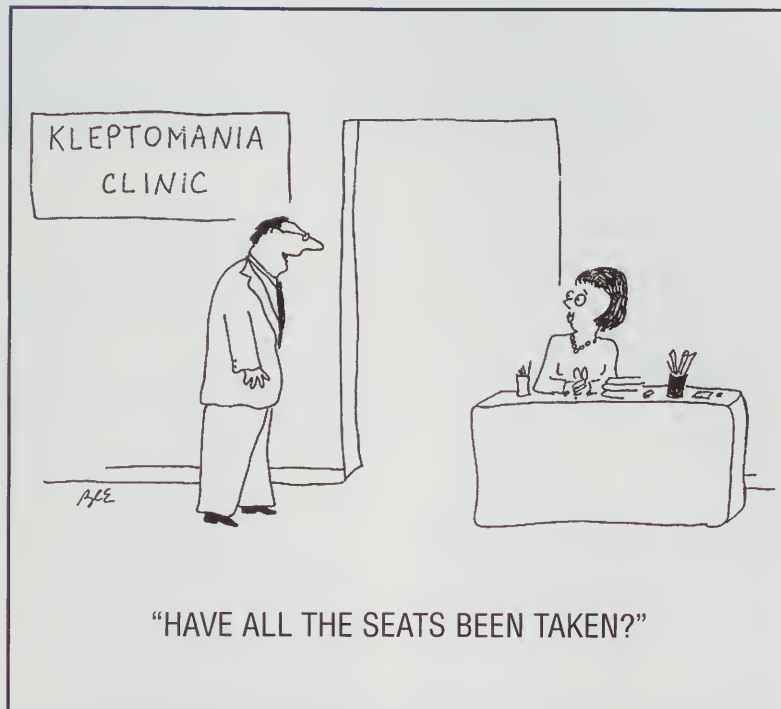
Kick Butts Day 1998

Tobacco advertising and peer pressure have a strong influence on children and smoking. Each day, 3,000 kids start smoking. The average youth smoker begins at age 13, quickly becoming a daily smoker.

Join youth, parents, teachers, and community leaders for Kick Butts Day 1998, on April 2, 1998. This nationwide celebration encourages youth leadership and activ-



ism, exposes the tobacco companies, and promotes a healthier future for children and teens. For a Kick Butts Day kit, contact the Campaign for Tobacco-Free Kids, telephone 202/296-5469, or www.kickbuttsday.org. At the state level, New Jersey Breathes (NJB), an independent tobacco-control initiative convened by MSNJ, continues to aggressively promote a healthy non-smoking attitude among Garden State children and teens. Get updates about NJB at www.kickbuttnj.com.



Counties get thumbs up

MSNJ President Carl Restivo, Jr, MD, awarded the Morris County Medical Society the 1997 President's Award for an outstanding job in maintaining current members and recruiting new members. As the county with the greatest net increase in regular membership, Morris County Medical Society received \$1,000.

Five county medical societies earned extra cash—up to \$1,900. Thanks to

MSNJ, net bonus payments for 1997 were given to Atlantic County Medical Society, Gloucester County Medical Society, Medical Society, Hunterdon County Medical Society, Middlesex County Medical Society, and Morris County Medical Society.



JaNoel Bess

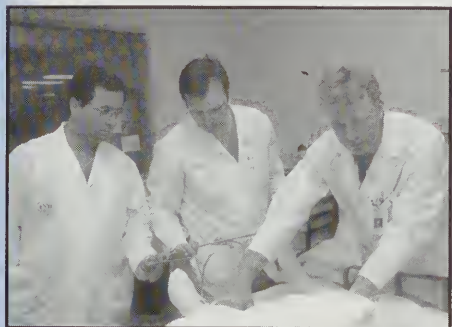
Contact JaNoel Bess, director of Membership, at MSNJ (609/896-1766) for incentives to help recruit and retain members for your county medical society.



DOCTORS MAKE A DIFFERENCE

Long hours, paperwork, and stress are the daily dose for physicians. But ask physicians and they'll tell you it's the best job in the world.

This year for Doctors' Day (March 30), the MSNJ Alliance celebrates New Jersey doctors. The Doctors' Day Gala will honor the hard work and dedica-



tion of New Jersey physicians with a special tribute to those physicians who have gone the extra mile. Proceeds from this event will go to MSNJ's Physicians' Health Program and the AMA's Education Research Foundation.

The first observance of Doctors' Day, held in 1933 by the Barrow County, Georgia, Auxiliary, included cards mailed to doctors and their wives and flowers for the graves of deceased physicians. The event culminated in 1990 with President George Bush's signature designating March 30 as National Doctors' Day.

The Doctors' Day Gala will be held on March 28, 1998, at the PNC Art Center in Holmdel. Contact the MSNJ Alliance for ticket information at 609/896-1766, extension 254.

DNR steps forward

MSNJ has been a strong force in achieving a small victory for patients who wish to refuse medical treatment. The New Jersey state Board of Medical Examiners (BME) has agreed to reconsider its policy requiring three physicians to evaluate a patient's competency before entering a do-not-resuscitate (DNR) order. Meanwhile, BME will not pursue action against attending physicians entering a DNR on behalf of their patients. MSNJ will continue to push for a full amendment of the BME policy.



Left to right: Bonnie Kelly, Neil Weisfeld, Bauman, Lorraine Martin, Paul Armstrong attend the hearing.

This news came following testimony by MSNJ, including special counsel Paul W. Armstrong, Esq., national biomedical ethicist Susan Bauman, MD, vice-chair of the MSNJ Committee on Biomedical Ethics; and Lorraine Martin, RN, consultant to the MSNJ Committee on Biomedical Ethics.

Representing physician interests

Paul W. Armstrong, Esq., one of the nation's leading bioethicists and physician advocates, has become Of Counsel to the law firm of Kern Augustine Conroy & Schoppmann, PC. The firm concentrates its efforts on the representation of physicians and their interests. Armstrong represented MSNJ before the U.S. Supreme Court where he successfully advocated against a constitutional right to physician-assisted suicide. Armstrong also is a professor of law at Rutgers University Law School and at UMDNJ. Currently, Armstrong is presenting MSNJ interests in the case of *In re W.C.*, where the attorney general of New Jersey has brought an action before the state Board of Medical Examiners, seeking to suspend a physician's license because she refused to permit a warrantless search of every file document, drawer, and cabinet in her office.



Paul W. Armstrong

continued on page

New Jersey MEDICINE

Health Care in the Garden State

April 1998

**DO YOU
BANK ON**

**S VIEWS
AIDS**

**IENT-DRIVEN
METIC
GERY**

OSURE



**Vandervalk on
health care in Trenton**

Y - O - U - R

PRACTICE

MADE MORE

PERFECT

WITH OVERHEAD EXPENSE INSURANCE FROM BLANKSTEEN

If you get sick, we'd like to help keep your practice well with overhead expense coverage that can reimburse office salaries, rent, insurance premiums, and utilities during an extended disability. Your needs are special, so call and talk with us. The only time to draw a blank in your insurance is when you fill it in with Blanksteen.



The _____ steen Companies

The Blanksteen Companies 253 Washington Street Jersey City, NJ 07302 201-333-4340 1-800-BLANK-AG
The Blanksteen Companies 161 William Street New York, NY 10038 212-732-9435 1-800-BLANK-AG
The MEDICAL SOCIETY OF NEW JERSEY endorsed plans, including Professional Overhead Expense underwritten by National Casualty Company.

JUL 13 1998

AUSTIN, TEXAS

New Jersey MEDICINE

newsWATCH

Expect fraud to become a greater part of your life. Both federal and state authorities have launched initiatives predicated on the idea that insurance fraud—committed by insureds, imposters, and health care providers—is a major contributor to health expenditures.

On the state level, the lame-duck session of the Legislature, meeting before the newly elected Legislature, produced the Health Care Claims Fraud Act promoted by Attorney General **Peter Verniero**. The new law criminalizes the submission of fraudulent medical bills and mandates the suspension of offenders' professional licenses.

On the federal level, the Federal Bureau of Investigation (FBI) reportedly now employs 375 agents dedicated to finding health care fraud. The 1997 Balanced Budget Act and the 1996 Kennedy-Kassebaum Health Insurance Portability and Accountability Act contained huge increases for this FBI effort and for the Office of the Inspector General, Department of Health and Human Services.

The New Jersey state Board of Medical Examiners (BME) has backed off its guideline requiring three physicians to evaluate and attest to the competence of the patient before a do-not-resuscitate order could be entered or life-sustaining medical treatment withdrawn. On March 11, BME, led by President **Bernard Robins, MD**, agreed to hold hearings in preparation for adopting a new approach.

Facilitating BME's change of direction were diverse national and state experts in biomedical ethics and law. American

Medical Association (AMA) counsel **Leonard Nelson** addressed BME, commenting that "each day of delay" in effecting a change hurts patients and the health care system. MSNJ has led the drive toward change.

AMA Board of Trustees vice-chair Randolph D. Smoak, Jr, MD, highlighted the new American Medical Accreditation Program (AMAP) in testimony before a congressional committee concerned with health care quality. AMAP is the physician-led effort, pioneered in New Jersey, to prevent duplication and to improve standards in verifying credentials and inspecting offices.

Applications to AMAP are free to New Jersey physicians before April 30. Call the AMAP hotline at 888/881-2627.

The AMA also is supporting the proposed federal bill of rights for health care consumers. The proposal has encountered opposition from the insurance and business communities, and Speaker of the House **Newt Gingrich** has come out for a go-slow approach.

Experts argue over the cost of health care consumer protections. For example, the actuarial firm of Milliman & Robertson predicts that the Patient Access to Responsible Care Act, sponsored by Representative **Charlie Norwood**, Republican of Georgia, would increase premiums 23 percent.

But, **Donald Muse**, former chief Medicare and Medicaid analyst for the Congressional Budget Office, projects a rise of only 0.7 to 2.7 percent. According to *Medicine & Health*, Muse says his analysis incorporates clarifying bill language.

More consumer information is a central feature of both federal and state pro-consumer efforts. Yet, HMO consumer data

now appear to contain large errors. **Jeffrey Kang, MD**, the chief medical officer for the Health Care Financing Administration—the federal agency that runs Medicare and Medicaid—reported “serious problems” in HEDIS data.

Bruce Fried, who formerly headed the HMO office in HCFA, says “information erred consistently in plans’ favor,” according to *Medicine & Health*. The newsletter also noted that one-fourth of HMOs in New Jersey could not submit verifiable information to the state Department of Health and Senior Services, which fined two of them.

Physicians, too, are increasingly called on to produce data for consumers. The new HEDIS 3.0 system requires HMOs to ask physicians about specific aspects of patient care.

In other lame-duck legislating, New Jersey’s solons passed a bill requiring all practicing physicians to obtain medical malpractice insurance or else obtain a letter of credit. BME is considering regulations implementing the requirement.

BME’s strategy and capacity for determining compliance are unclear. Until an enforcement approach is made plain, physicians and podiatrists covered by the bill perhaps can assume a wait-and-see attitude. But, “going bare” now is an even riskier decision than before.

No great new demand for malpractice coverage is expected. Few physicians did indeed forswear coverage, and the Legislature did not identify uncovered physicians.

The Healthcare Leadership Review has summarized several journal articles and presentations on trends in managed care. Let’s mention five.

First, “co-opetition” is verdant jargon for the new spring season. Coined, or at

least put into circulation, by **Russell C. Coile, Jr.**, of Chi Systems in Southfield, Michigan, the term captures the point when market competitors switch to cooperation in order to maximize their positions.

Second, by offering “carve-out” products, specialty networks are emerging as a real threat to integrated delivery networks. According to **M. Shane Foreman** and **Stuart Friedman**, the carve-outs include hospital programs for diabetes and other disease states, physician networks and group practices, and disease management companies that contract with direct care providers.

Third, quality-based pay for physicians remains the exception, state writer **Larry Stevens** and Towers Perrin analyst **Joseph Levitch**. As noted above, valid data on quality are not easily obtained. In the absence of data, how will patients choose physicians? Primarily on the basis of impressions, it appears.

Fourth, does the shift to managed care create intolerable paperwork burdens for physicians? Here’s a counterintuitive finding for you. In *Medical Economics*, **Neil Chesanow** reports that physicians expend only 3 percent of their work week on insurance paperwork, regardless of their degree of involvement in HMOs.

Finally in our *Healthcare Leadership Review* round-up, the California Managed Health Care Improvement Task Force, chaired by economist **Alain Enthoven, PhD**, may spur nationwide interest in new avenues of reform.

Managed Care Outlook reports the task force recommendations, which include risk-adjusted premiums, new regulatory and dispute resolution mechanisms, a shift away from pre-authorization and toward credentialing, and more consumer involvement featuring—what else?—better data.

Neil E. Weisfeld

NJM

“I KNOW NO
WAY OF JUDGING
THE FUTURE
BUT BY THE PAST.”



As a Princeton Insurance Company policyholder, your professional and financial future isn't written in the stars, but in the history books: Princeton has had a long-standing commitment to meet the professional liability insurance needs of doctors. That includes a track record of vigorously defending our insureds against frivolous malpractice claims and a rate structure that rewards doctors with good experience.

To help secure *your* future, consult one of the independent agents who represent Princeton or call us at **1-800-433-0157**.



Princeton Insurance Company

Professional Liability

Office Package Policy

Workers Compensation

Rated A- (Excellent) by A.M. Best Company 746 Alexander Road • Princeton, New Jersey 08540

REVIEW BOARD

Sofia Anthony, MD
 Paul W. Armstrong, Esq
 Richard M. Ball, MD
 Stanley S. Bergen, Jr, MD
 Harry M. Carnes, MD
 Gary S. Carter
 Elizabeth G. Christopherson
 Ellen M. Cosgrove, MD
 The Honorable Len Fishman
 Joseph E. Gonzalez, Jr
 Paul J. Hirsch, MD
 Ismail Kazem, MD
 Louis L. Keeler, MD
 Carol J. Kientz, RN
 James R. Knickman, PhD
 Paul R. Langevin, Jr
 George R. Laufenberg
 Martin S. Levine, DO
 Henry R. Liss, MD
 Gregg Lubinsky, RPh
 Ruth B. Mandel
 Michael R. McGarvey, MD
 Julane Miller
 Charles M. Moss, MD
 Patricia Murphy, PhD, RN
 Tom O'Neill
 Fred M. Palace, MD
 Mary Todd, DO
 William H. Tremayne
 F. Kevin Tylus
 The Honorable Charlotte Vandervalk
 Joan Verplanck
 Paul E. Wallner, DO

COUNCIL ON COMMUNICATIONS

Charles M. Moss, MD, Chair	Joseph W. Kozielski, MD
Harry M. Carnes, MD, Vice-Chair	Clement H. Kreider, Jr, MD
Henry R. Liss, MD, Vice-Chair	Alan J. Lippman, MD
Richard M. Ball, MD	Robert M. MacMillan, MD
John P. Capelli, MD	George J. Mellendick, MD, MPH
Paul J. Carniol, MD	Donald W. Orth, MD
Andrew B. Covit, MD	Robert M. Pallay, MD
Anthony Del Gaizo, MD	Sindy M. Paul, MD
Joseph A. DiLallo, MD	Arthur W. Perry, MD
Michael J. Doyle, MD	Leon G. Smith, MD
Leigh E. Ende, MD	Niranjana V. Rao, MD
Steven C. Fiske, MD	Kelly M. Reid, MD
Jack Goldberg, MD	Carl Restivo, Jr, MD
Daniel P. Greenfield, MD, MPH	John C. Riggs, MD
George H. Hansen, MD	R. Gregory Sachs, MD
M. Arif Hashmi, MD	John D. Slade, MD
Christine E. Haycock, MD	Leon G. Smith, MD
Neil B. Horner, MD	Bessie M. Sullivan, MD
Walter J. Kahn, MD	Julie E.K. Timins, MD
Monroe S. Karetzky, MD	Sandra S. Valdez, MD
Ismail Kazem, MD	Paul E. Wallner, DO
Louis L. Keeler, MD	Richard A. Williams, MD
Scott P. Keil, MD	Angie Campo
	Eileen Martin Cohen
	Anna Miranda

New Jersey MEDICINE

Health Care in the Garden State

EDITOR-IN-CHIEF
 Howard D. Slobodien, MD

EXECUTIVE EDITOR
 Geraldine R. Hutner, MA

ASSISTANT EDITOR
 Nancy M. Propsner, BA

ADVERTISING
 Cookson Media Services

PRODUCTION
 Trenttypo, Inc.

PRESIDENT AND CHAIR
 Carl Restivo, Jr, MD

PRESIDENT-ELECT
 R. Gregory Sachs, MD

FIRST VICE-PRESIDENT
 Irving P. Ratner, MD

SECOND VICE-PRESIDENT
 Walter J. Kahn, MD

SECRETARY
 Bessie M. Sullivan, MD

TREASURER
 Eileen M. Moynihan, MD

IMMEDIATE PAST-PRESIDENT
 Anthony P. Caggiano, Jr, MD

BOARD OF TRUSTEES
 S. Manzoor Abidi, MD
 Sievan Adler, MD
 Angelo S. Agro, MD
 Churchill L. Blakey, MD
 Donald J. Cinotti, MD
 Rajendra Prasad Gupta, MD
 David A. Ingis, MD
 Philip J. Jasper, MD
 Elliot M. Kraus, MD
 Giovanni Lima, MD
 Mark T. Olesnick, MD
 Robert S. Rigolosi, MD
 Michael J. Spedick, MD
 John W. Spurlock, MD
 J. Jerome Cohen, MD, OMSS
 Andrew Kunish, MD, Speaker of the House
 Susan Kahn, MSNJ Alliance
 John Y. Lee, Medical Student
 Daniel M. Greenwald, MD, Medical Specialty Societies

New Jersey MEDICINE (ISSN-088-5842-X) is published monthly (since 1904) under the direction of the Council on Communications by the Medical Society of New Jersey (MSNJ), Two Princess Road, Lawrenceville NJ 08648. Printed in Lancaster, PA, by Lancaster Press. Printed in USA. Whole number of issues 1126. Member's subscription (\$10) is included in MSNJ dues. Rates for nonmembers are \$50; outside of USA, add \$20. Single copy is \$7.50. Periodicals postage paid at Trenton, NJ, and Lancaster, PA. Copyright 1998 by MSNJ. April 1998. Internet address: <http://www.msnj.org>. E-mail address: info@MSNJ.org. 609/896-1766. FAX 609/896-1368. Postmaster: Send address changes to New Jersey MEDICINE, Two Princess Road, Lawrenceville NJ 08648. The appearance of advertising in New Jersey MEDICINE is not a MSNJ guarantee or endorsement of the product or service, by the advertiser. When MSNJ has endorsed a product or program, that will be expressly noted.

Medical Society of New Jersey
MSNJ

Critical Treatment for the Future of Your Practice...



Before It's Too Late

Wilentz, Goldman & Spitzer's Health Care Law Practice Group serves health care professionals regarding: group practice formation and operations; management service organizations (MSOs); physician practice management companies (PPMCs); managed care contracting; physician-hospital organizations (PHOs); independent

physician associations (IPAs); restrictive covenants; and regulatory, employment, tax and litigation matters. **Think of us as preventive medicine for your practice.** *For information please call our Health Care Law Practice Group Co-Chairs: Michael F. Schaff at (732) 855-6047 or Francis V. Bonello at (732) 389-5636.*

**WILENTZ
GOLDMAN
& SPITZER**
ATTORNEYS AT LAW

"Helping The Health Care Professional"

Woodbridge, NJ • Eatontown, NJ • New York, NY

<http://www.newjerseylaw.com>

C O N T E N T S

- 31** IN THE SPOTLIGHT
Interview with Charlotte Vandervalk
By Bill Berlin, PhD
- 35** HEALTH CARE FEATURE
Blood you can bank on
By Sheila Smith Noonan
- 39** CURRENT TRENDS
What do New Jersey adolescents know about AIDS?
By Jane E. Miller, PhD; Barbara C. Mundo
- 49** CLINICAL REPORT
Changing the outlook of gastroenterology
By M. Arif Hashmi, MD
- 53** PUBLIC HEALTH ADVANCES
Cosmetic surgery hits mainstream New Jersey
By Robin K. Levinson
- 57** PUBLIC HEALTH ADVANCES
DES-exposed mothers, daughters, and sons
By Robin Rapport
- 61** SPECIAL REPORT
Hope on the horizon for stroke patients
By Diane Haring Cornell
- 65** COMMENTARY
The natural role of hospice care at the end of life
By Mark Wegryn, MPH
- 69** COMPUTERS IN MEDICINE
Computer as menace: Repetitive stress injury
By Eric J. Lerner

NEWSWATCH 1

MAIL STOP 10

NEWSMAKERS 15

ONLINE MSNJ 18

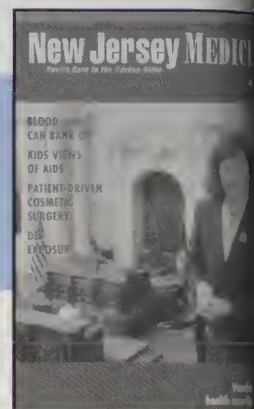
EDITOR'S DESK 21

GUEST EDITORIAL 25

MEMBERSHIP MATTERS 27

CALENDAR 72

F.Y.I. 80

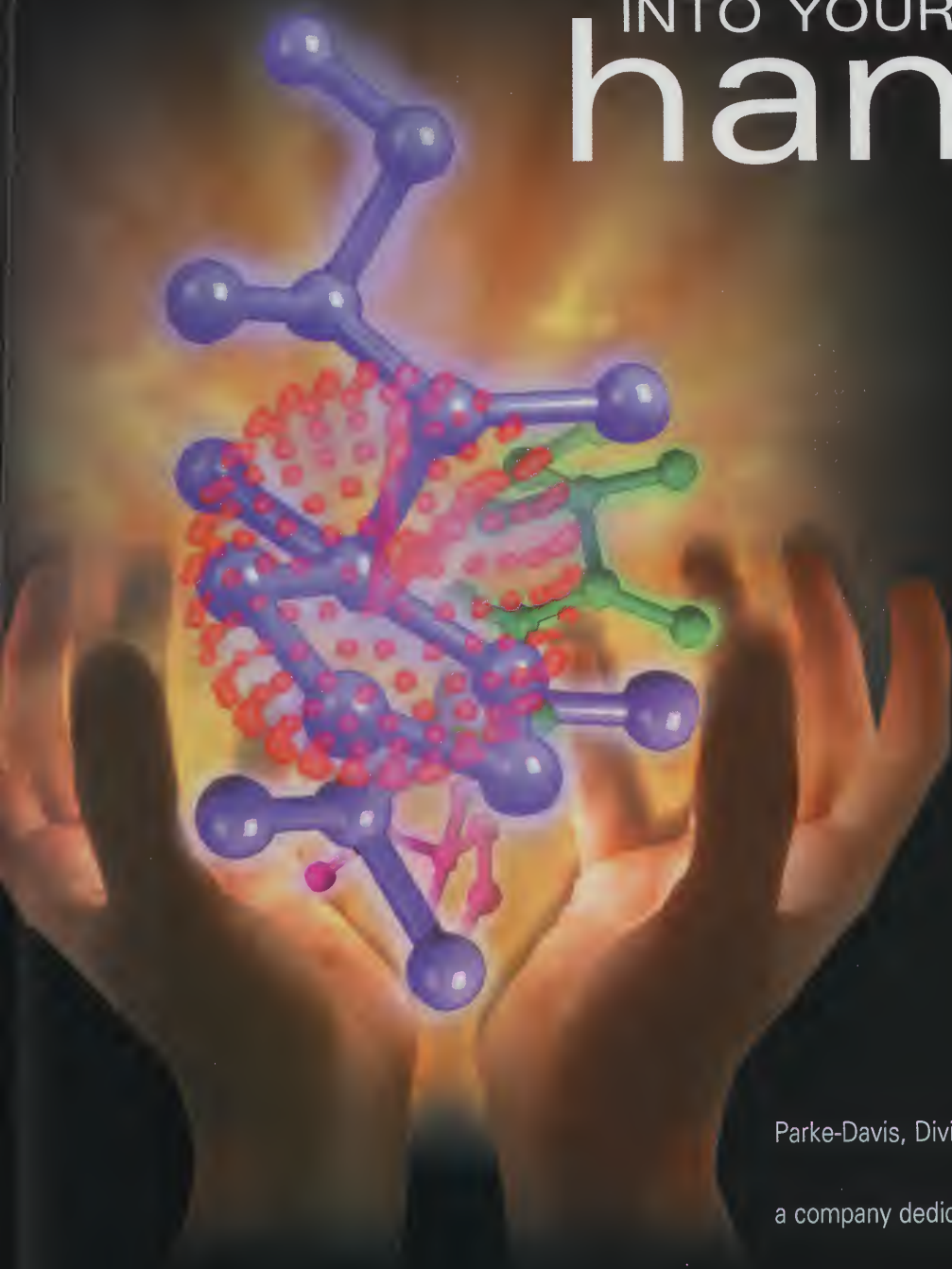


© Conrad

Working with a
plex health care sys
Assemblywoman C
lotte Vandervalk is r
toring the system
Trenton.

Cover: © Conrad Glo

PUTTING THE POWER OF
advanced medicine
INTO YOUR
hands



Parke-Davis, Division of Warner-Lambert...

a company dedicated to turning innovative

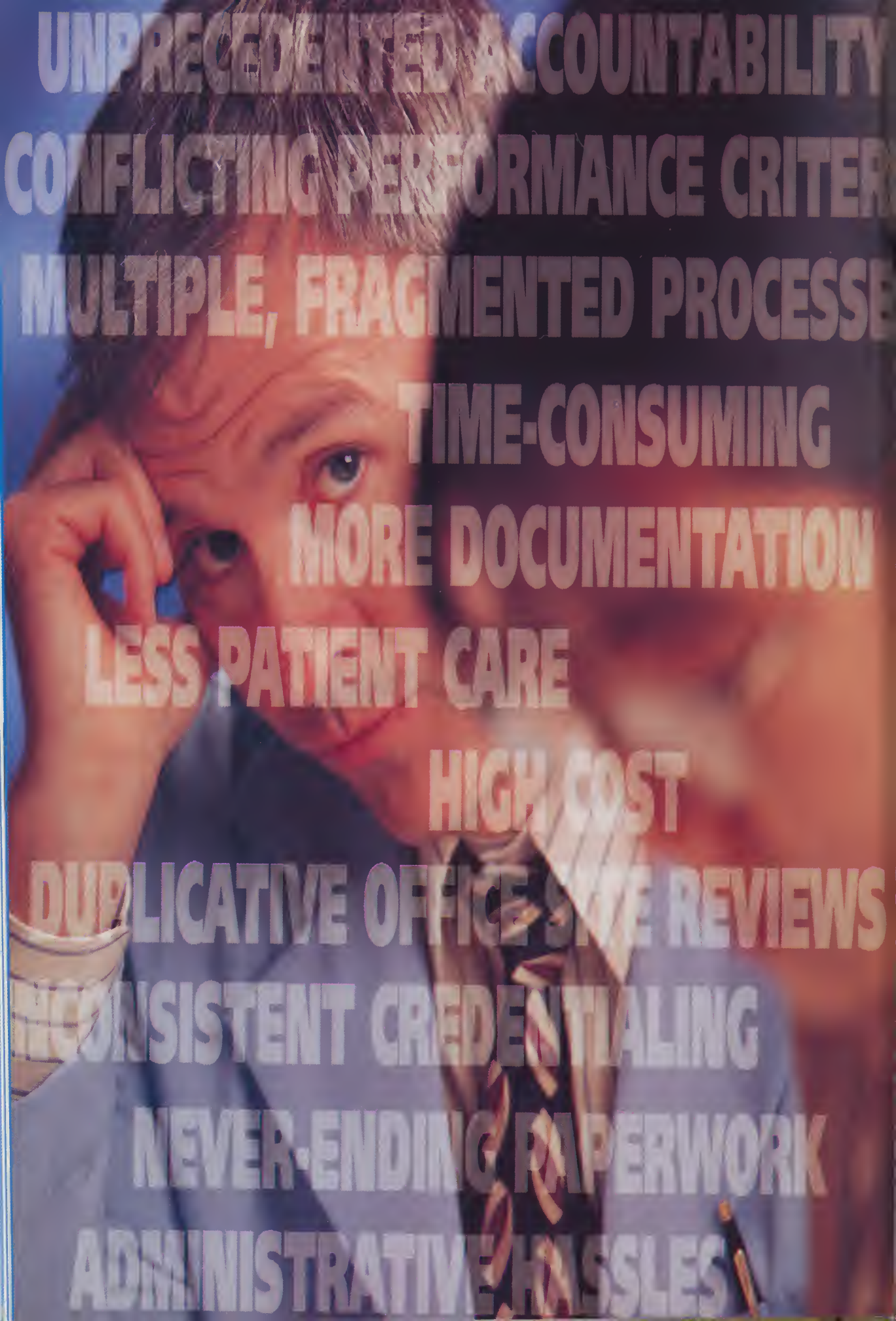
ideas into available new treatment options

as rapidly and efficiently as possible.



Division of Warner-Lambert Company
Morris Plains, New Jersey 07950

PD-99-JA-2422-A1(038)
810036



UNPRECEDENTED ACCOUNTABILITY
CONFLICTING PERFORMANCE CRITERIA
MULTIPLE, FRAGMENTED PROCESSES
TIME-CONSUMING
MORE DOCUMENTATION
LESS PATIENT CARE
HIGH COST
DUPLICATIVE OFFICE SITE REVIEWS
INCONSISTENT CREDENTIALING
NEVER-ENDING PAPERWORK
ADMINISTRATIVE HASSLES

Our solution has arrived.

One Time

One Source

One Standard



American
Medical
Accreditation
Program

The new American Medical Accreditation Program (AMAP), physicians
make an application **ONE TIME**, have their credentials primary-source
verified **ONE TIME**, and have an on-site office review **ONE TIME**.

AMAP then provides an Accreditation report and certificate to each physician
who meets the AMAP national standard.

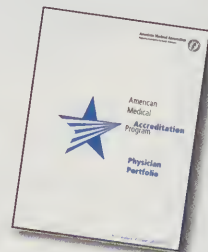
AMAP will provide a complete portfolio of verified credentials, office site
visit and other frequently requested information to each health plan and
employer that uses AMAP and with whom the physician is affiliated.

The American Medical Accreditation Program is a voluntary, comprehensive
accreditation program that measures and evaluates individual physicians
against national standards, criteria and peer performance in five areas:
Credentials, Personal Qualifications, Environment of Care,
Clinical Performance, and Patient Care Results.

Meeting and maintaining AMAP's high standard earns a physician AMAP
Accreditation – a new national benchmark of physician quality.

AMAP, your one source for the new national standard of physician quality
information, has arrived.

To learn more about the many benefits
AMAP has to offer *your* organization,
call the AMAP Resource Center at
1-888-881-AMAP (2627) or visit the AMAP
Web site at <http://www.ama-assn.org>.



The standard in quality physician care.

American Medical Association
Physicians dedicated to the health of America





New Jersey MEDICINE

New Medicare coverage

The Home Health Assembly (HHA) of New Jersey would like to share information with the medical community. Please be assured that agencies are continuing to try to provide full, high-quality home care services to the patients and families in their surrounding communities. However, changes in the Medicare home health benefit are taking place and physician offices are likely to receive calls of concern from patients and their families. The changes are troubling for patients, and confusing as well. Thus, HHA provides the following information to assist physicians and their staff in responding to inquiries.

Discontinuance of the Medicare venipuncture home care benefits. In the past, if a Medicare home care patient needed periodic blood work, ordered by the physician, Medicare would cover the cost of that service by a visiting nurse from a Medicare-certified home health agency. In addition, because the patient required a "qualifying skilled

service" (a registered nurse for the venipuncture), Medicare also would cover part-time home health aide services for patients who also needed help with personal care, bathing, toileting, or ambulation.

As part of the Balanced Budget Act of 1997, it was determined that Medicare no longer will consider venipuncture to be a qualifying service that entitles patients to the home health benefit (nursing and home health aide visits). This took effect on February 5, 1998. While the patient may continue to need support care such as bathing and toileting, Medicare will not pay for that care if the patient also does not need a skilled service (the services of a registered nurse,

physical therapist, occupational therapist, or speech therapist).

Therefore, patients whose only skilled home care service need is venipuncture no longer will qualify for Medicare home care coverage. Our New Jersey home health agencies and agencies across the country are in the process of advising their venipuncture-only patients that Medicare coverage ended February 5, 1998. They also are trying to help patients find other resources to meet their needs, though the options are quite limited.

If the patient can afford to pay privately for home care, then the agency will be able to continue uninterrupted services through that reimbursement method. If the patient also qualifies for Medicaid, then it is

continued on page 12

Requirements for letters

To submit a letter, FAX (609/896-1368), e-mail (info@MSNJ.org), or mail your letter to *New Jersey MEDICINE*, Two Princess Road, Lawrenceville NJ 08648. Letters should be typed and double-spaced and should be no longer than 400 words with up to 4 references, if necessary. Include your full name, affiliation, address, and telephone number.

Letters are published at the discretion of the editor-in-chief and are subject to editing and abridgment. Letters may be published on MSNJ's web site, <http://www.msnj.org>. Financial associations or other possible conflicts of interest must be disclosed. Letters represent the opinions of the authors.

Beyond Medicines that Help and Heal. What More Could You Expect from the Medicine Chest of the Nation?

Quite a lot more, based on a 1997 impact study conducted by Coopers & Lybrand L.L.P.* reporting that New Jersey's pharmaceutical and medical device companies make a significant contribution to just about every aspect of life in the Garden State.

For example, the pharmaceutical and medical device industry in New Jersey:

- *Generated \$8 billion in annual economic activity in 1996.*
- *Employs more than 60,000 workers from 115 locations in 70 municipalities in 16 counties.*
- *Paid \$3.2 billion in salaries and wages to employees in New Jersey.*
- *Leads research and development on serious and life-threatening diseases including cancer, Alzheimer's disease, heart disease, diabetes, arthritis, AIDS and osteoporosis.*
- *Received almost one-third of all FDA approvals of significant new drugs from 1991-1996.*

Coming in the May Issue of *New Jersey Medicine*

Watch for a special editorial section on how New Jersey's pharmaceutical and medical device companies meet global healthcare needs while bolstering the Garden State's economy and improving the quality of life for all New Jerseyans.

**HealthCare
Institute of
New Jersey**



American Home Products Corp.
Becton Dickinson and Company
Bracco Diagnostics Inc.
Bristol-Myers Squibb Co.
C. R. Bard, Inc.
Hoffmann-La Roche Inc.
Hoechst Marion Roussel
Howmedica Inc. (Pfizer)

Johnson & Johnson
Knoll Pharmaceutical Company
Merck & Co., Inc.
Novartis Pharmaceuticals Corporation
Novo Nordisk
Nycomed Amersham Imaging Americas
Schering-Plough Corp.
Warner-Lambert Co.

*The Coopers & Lybrand findings draw upon survey information gathered from Institute members, as well as data available from public sources. The HealthCare Institute of New Jersey is a non-partisan trade association of 16 leading companies in New Jersey's research-based pharmaceutical, medical device and healthcare-related industries.

100 Albany Street
Suite 210
New Brunswick, NJ 08901
Ph: 732-342-8442
Fax: 732-342-8449

continued from page 10

probable that the agency can bill Medicaid instead of Medicare.

If the patient's finances are limited, most agencies can do a "financial screening" and offer some assistance through a reduced fee or no-fee option (home health agencies do not receive any charity care assistance from the state, but they do provide charity care to the best of their limited ability). In some cases, the only real need of the patient is the blood work itself. In those cases, a physician's office may want to suggest a qualified laboratory, which can send a technician to the home to carry out the blood work. Medicare Part B may be billed for part of that cost, though it is a very small sum, that will be paid by Medicare. The patient probably will need to cover some of the cost as well. And, of course, if the patient is able to travel with assistance, then the blood work could be done in the physician's office, a clinic setting, or a laboratory approved by the physician.

Each situation is unique, and home health agencies are doing their best to explain all of this to their patients. It is a frightening time for these patients, and some already have called their physicians and/or legislators to ask for help or further informa-

tion. HHA always is available as a resource.

The Interim Payment System (IPS). The Balanced Budget Act of 1997 ordered that a new Interim Payment System be developed and applied to home health agency Medicare reimbursement as of January 1, 1998. When the structure of that IPS method became clear in fall 1997, its impact on New Jersey home health agencies was severe. Medicare reimbursement to most agencies in our state will be cut anywhere from \$500,000 to several million dollars in 1998 alone. The only way agencies will have to survive such onerous reductions is to reduce costs through fewer visits and/or fewer staff. Thus, some home health patients may receive fewer visits than in the past, though we are trying desperately to avoid such service cuts.

HHA also is working closely with our New Jersey congressional delegation to urge that these Medicare reimbursement methods be modified. The support we have received from all our congressional representatives is heartening, and efforts will continue at the federal level.

These are trying times for everyone in the health care system, and we recognize the need

for cost-effective services and elimination of any unnecessary care. New Jersey has one of the finest records for cost-conscious high-quality home care in the nation. Our home health agencies already achieve top notch outcomes with a minimum number of visits per patient per year on average. Thus, further reductions in visits are particularly difficult for us, but our agencies will do their best to maintain quality within the limits of Medicare's reduced reimbursement.

As you receive inquiries about these issues, we hope this will help to put the situation in perspective. Home health agencies in New Jersey are not imposing these changes upon their patients and your patients. Changes in Medicare regulations and reimbursement are causing the cutbacks.

*Carol J. Kientz, RN, MS
Executive Director,
Home Health Assembly of NJ*

Editor's note. Kientz flushes out the concerns of those experienced in this area. All interested persons should petition Congress to use some of the "budget surplus" to restore the imbalance in Medicare programs. We need more, not fewer, programs.

NJM

For patients suffering from
chronic idiopathic urticaria

the Performance of hydroxyzine ... *Without Sedation*

CLARITIN® delivers proven efficacy vs hydroxyzine¹

- The percent of CLARITIN® patients reporting marked or complete relief of urticaria symptoms was comparable to the percent of hydroxyzine patients, and greater than the percent of patients taking placebo

CLARITIN® delivers a proven nonsedating* safety profile

CLARITIN® offers 24-hour coverage and distinct patient benefits

- Nonsedating* CLARITIN® offers the convenience of q.d. dosing (vs t.i.d. dosing for hydroxyzine), acceptance on over 93% of formularies, and the proven track record of over 4 billion patient days worldwide

"Nothing but blue skies from now on"

Controlled clinical trials in seasonal allergic rhinitis patients using the recommended dose, the incidence of headache (12%), somnolence (8%), fatigue (4%), and dry mouth (3%) with CLARITIN® was similar to that of placebo (12%, 6%, 3%, and 2%, respectively).

The incidence of sedation with CLARITIN® (8%) was similar to that of placebo (6%) at the recommended dose.

Studies with CLARITIN® at doses 2 to 4 times higher than the recommended dose of 10 mg, dose-related increase in the incidence of sedation was observed.

¹Monroe EW, Bernstein DI, Fox RW, et al. Relative efficacy and safety of loratadine, hydroxyzine, and placebo in chronic idiopathic urticaria. *Arzneim.-Forsch./Drug Res.* 1992;42:1119-1121.

Once-a-day

Claritin®
10 mg (loratadine)
TABLETS

Please see next page for brief summary of Prescribing Information.

CLARITIN®

brand of loratadine

TABLETS, SYRUP, and RAPIDLY-DISINTEGRATING TABLETS

BRIEF SUMMARY (For full Prescribing Information, see package insert.)
INDICATIONS AND USAGE: CLARITIN is indicated for the relief of nasal and non-nasal symptoms of seasonal allergic rhinitis and for the treatment of chronic idiopathic urticaria in patients 6 years of age or older.

CONTRAINDICATIONS: CLARITIN is contraindicated in patients who are hypersensitive to this medication or to any of its ingredients.

PRECAUTIONS: General: Patients with liver impairment or renal insufficiency (GFR < 30 mL/min) should be given a lower initial dose (10 mg every other day). (See **CLINICAL PHARMACOLOGY: Special Populations**.)

Drug Interactions: Loratadine (10 mg once daily) has been coadministered with therapeutic doses of erythromycin, cimetidine, and ketoconazole in controlled clinical pharmacology studies in adult volunteers. Although increased plasma concentrations (AUC 0-24 hrs) of loratadine and/or descarboethoxyloratadine were observed following coadministration of loratadine with each of these drugs in normal volunteers (n = 24 in each study), there were no clinically relevant changes in the safety profile of loratadine, as assessed by electrocardiographic parameters, clinical laboratory tests, vital signs, and adverse events. There were no significant effects on QTc intervals, and no reports of sedation or syncope. No effects on plasma concentrations of cimetidine or ketoconazole were observed. Plasma concentrations (AUC 0-24 hrs) of erythromycin decreased 15% with coadministration of loratadine relative to that observed with erythromycin alone. The clinical relevance of this difference is unknown. These above findings are summarized in the following table:

Effects on Plasma Concentrations (AUC 0-24 hrs) of Loratadine and Descarboethoxyloratadine After 10 Days of Coadministration (Loratadine 10 mg) in Normal Volunteers

	Loratadine	Descarboethoxyloratadine
Erythromycin (500 mg Q8h)	+ 40%	+46%
Cimetidine (300 mg QID)	+103%	+ 6%
Ketoconazole (200 mg Q12h)	+307%	+73%

There does not appear to be an increase in adverse events in subjects who received oral contraceptives and loratadine.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: In an 18-month carcinogenicity study in mice and a 2-year study in rats, loratadine was administered in the diet at doses up to 40 mg/kg (mice) and 25 mg/kg (rats). In the carcinogenicity studies, pharmacokinetic assessments were carried out to determine animal exposure to the drug. AUC data demonstrated that the exposure of mice given 40 mg/kg of loratadine was 3.6 (loratadine) and 18 (descarboethoxyloratadine) times higher than in humans given the maximum recommended daily oral dose. Exposure of rats given 25 mg/kg of loratadine was 28 (loratadine) and 67 (descarboethoxyloratadine) times higher than in humans given the maximum recommended daily oral dose. Male mice given 40 mg/kg had a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) than concurrent controls. In rats, a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) was observed in males given 10 mg/kg and males and females given 25 mg/kg. The clinical significance of these findings during long-term use of CLARITIN is not known.

In mutagenicity studies, there was no evidence of mutagenic potential in reverse (Ames) or forward point mutation (CHD-HGPRT) assays, or in the assay for DNA damage (rat primary hepatocyte unscheduled DNA assay) or in two assays for chromosomal aberrations (human peripheral blood lymphocyte clastogenesis assay and the mouse bone marrow erythrocyte micronucleus assay). In the mouse lymphoma assay, a positive finding occurred in the non-activated but not the activated phase of the study.

Decreased fertility in male rats, shown by lower female conception rates, occurred at an oral dose of 64 mg/kg (approximately 50 times the maximum recommended human daily oral dose on a mg/m² basis) and was reversible with cessation of dosing. Loratadine had no effect on male or female fertility or reproduction in the rat at an oral dose of approximately 24 mg/kg (approximately 20 times the maximum recommended human daily oral dose on a mg/m² basis).

Pregnancy Category B: There was no evidence of animal teratogenicity in studies performed in rats and rabbits at oral doses up to 96 mg/kg (approximately 75 times and 150 times, respectively, the maximum recommended human daily oral dose on a mg/m² basis). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, CLARITIN should be used during pregnancy only if clearly needed.

Nursing Mothers: Loratadine and its metabolite, descarboethoxyloratadine, pass easily into breast milk and achieve concentrations that are equivalent to plasma levels with an AUC_{milk}/AUC_{plasma} ratio of 1.17 and 0.85 for loratadine and descarboethoxyloratadine, respectively. Following a single oral dose of 40 mg, a small amount of loratadine and descarboethoxyloratadine was excreted into the breast milk (approximately 0.03% of 40 mg over 48 hours). A decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. Caution should be exercised when CLARITIN is administered to a nursing woman.

Pediatric Use: The safety of CLARITIN Syrup at a daily dose of 10 mg has been demonstrated in 188 pediatric patients 6-12 years of age in placebo-controlled 2-week trials. The effectiveness of CLARITIN for the treatment of seasonal allergic rhinitis and chronic idiopathic urticaria in this pediatric age group is based on an extrapolation of the demonstrated efficacy of CLARITIN in adults in these conditions and the likelihood that the disease course, pathophysiology, and the drug's effect are substantially similar to that of the adults. The recommended dose for the pediatric population is based on cross-study comparison of the pharmacokinetics of CLARITIN in adults and pediatric subjects and on the safety profile of loratadine in both adults and pediatric patients at doses equal to or higher than the recommended doses. The safety and effectiveness of CLARITIN in pediatric patients under 6 years of age have not been established.

ADVERSE REACTIONS: CLARITIN Tablets: Approximately 90,000 patients, aged 12 and older, received CLARITIN Tablets 10 mg once daily in controlled and uncontrolled studies. Placebo-controlled clinical trials at the recommended dose of 10 mg once a day varied from 2 weeks' to 6 months' duration. The rate of premature withdrawal from these trials was approximately 2% in both the treated and placebo groups.

REPORTED ADVERSE EVENTS WITH AN INCIDENCE OF MORE THAN 2% IN PLACEBO-CONTROLLED ALLERGIC RHINITIS CLINICAL TRIALS IN PATIENTS 12 YEARS OF AGE AND OLDER

	LORATADINE 10 mg QD n = 1926	PLACEBO n = 2545	CLEMASTINE 1 mg BID n = 536	TERFENADINE 60 mg BID n = 684
Headache	12	11	8	8
Somnolence	8	6	22	9
Fatigue	4	3	10	2
Dry Mouth	3	2	4	3

Adverse events reported in placebo-controlled chronic idiopathic urticaria trials were similar to those reported in allergic rhinitis studies.

Adverse event rates did not appear to differ significantly based on age, sex, or race, although the number of nonwhite subjects was relatively small.

CLARITIN REDITABS (loratadine rapidly-disintegrating tablets): Approximately 100 patients received CLARITIN REDITABS (loratadine rapidly-disintegrating tablets) in clinical trials of 2 weeks' duration. In these studies, adverse events were similar in type and frequency to those seen with CLARITIN Tablets and placebo.

Administration of CLARITIN REDITABS (loratadine rapidly-disintegrating tablets) result in an increased reporting frequency of mouth or tongue irritation.

CLARITIN Syrup: Approximately 300 pediatric patients 6 to 12 years of age received loratadine once daily in controlled clinical trials for a period of 8-15 days. Among these children were treated with 10 mg loratadine syrup once daily in placebo-controlled trials. Adverse events in these pediatric patients were observed to occur with type and frequency those seen in the adult population. The rate of premature discontinuance due to adverse events in pediatric patients receiving loratadine 10 mg daily was less than 1%.

ADVERSE EVENTS OCCURRING WITH A FREQUENCY OF ≥ 2% IN LORATADINE SYRUP-TREATED PATIENTS (6-12 YEARS OLD) IN PLACEBO-CONTROLLED TRIALS AND MORE FREQUENTLY THAN IN THE PLACEBO GROUP

	LORATADINE 10 mg QD n = 188	PLACEBO n = 262	CHLORPHENIRAMINE 2-4 mg BID n = 170
Nervousness	4	2	2
Wheezing	4	2	5
Fatigue	3	2	5
Hyperkinesia	3	1	1
Abdominal Pain	2	0	0
Conjunctivitis	2	<1	1
Dysphonia	2	<1	0
Malaise	2	0	1
Upper Respiratory Tract Infection	2	<1	0

In addition to those adverse events reported above (≥ 2%), the following adverse events were reported in at least one patient in CLARITIN clinical trials in adult and pediatric patients:

Autonomic Nervous System: Altered lacrimation, altered salivation, flushing, hypotension, increased sweating, thirst.

Body As A Whole: Angioneurotic edema, asthenia, back pain, blurred vision, chest pain, ache, eye pain, fever, leg cramps, malaise, rigors, tinnitus, viral infection, weight gain.

Cardiovascular System: Hypertension, hypotension, palpitations, supraventricular arrhythmias, syncope, tachycardia.

Central and Peripheral Nervous System: Blepharospasm, dizziness, dysphonia, headache, migraine, paresthesia, tremor, vertigo.

Gastrointestinal System: Altered taste, anorexia, constipation, diarrhea, dyspepsia, gastritis, hiccup, increased appetite, nausea, stomatitis, toothache, vomiting.

Musculoskeletal System: Arthralgia, myalgia.

Psychiatric: Agitation, amnesia, anxiety, confusion, decreased libido, depression, concentration, insomnia, irritability, paranoia.

Reproductive System: Breast pain, dysmenorrhea, menorrhagia, vaginitis.

Respiratory System: Bronchitis, bronchospasm, coughing, dyspnea, epistaxis, hiccups, laryngitis, nasal dryness, pharyngitis, sinusitis, sneezing.

Skin and Appendages: Dermatitis, dry hair, dry skin, photosensitivity reaction, pruritus, rash, urticaria.

Urinary System: Altered micturition, urinary discoloration, urinary incontinence, retention.

In addition, the following spontaneous adverse events have been reported rarely during marketing of loratadine: abnormal hepatic function, including jaundice, hepatitis, and necrosis; alopecia; anaphylaxis; breast enlargement; erythema multiforme; peripheral edema; and seizures.

OVERDOSAGE: In adults, somnolence, tachycardia, and headache have been reported at overdoses greater than 10 mg with the Tablet formulation (40 to 180 mg). Extrapyramidal signs and palpitations have been reported in children with overdoses of greater than 10 mg CLARITIN Syrup. In the event of overdose, general symptomatic and supportive measures should be instituted promptly and maintained for as long as necessary.

Treatment of overdose would reasonably consist of emesis (ipecac syrup), except in patients with impaired consciousness, followed by the administration of activated charcoal to absorb any remaining drug. If vomiting is unsuccessful, or contraindicated, gastric lavage should be performed with normal saline. Saline cathartics may also be of value for rapid evacuation of bowel contents. Loratadine is not eliminated by hemodialysis. It is not known if loratadine is eliminated by peritoneal dialysis.

No deaths occurred at oral doses up to 5000 mg/kg in rats and mice (greater than 24 times the maximum recommended human daily oral dose on a mg/m² basis). Single oral doses of loratadine showed no effects in rats, mice, and monkeys at doses up to 10 times the maximum recommended human daily oral dose on a mg/m² basis.

Schering

Schering Corporation
Kenilworth, NJ 07033 USA

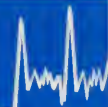
1/97

1962840C

CLARITIN REDITABS (loratadine rapidly-disintegrating tablets) are manufactured for Schering Corporation by Schering DDS, England.

U.S. Patent Nos. 4,282,233 and 4,371,516.

Copyright © 1997, Schering Corporation. All rights reserved.



Air Force promotion

MSNJ member **Michael Palmer, MD**, has been promoted to chief of Aerospace Flight Medicine with the 439th Medical Squadron at Westover, Massachusetts. Palmer has served nine years as an Air Force flight surgeon and 13 years as an intelligence officer. Palmer is on staff at Princeton Orthopaedic Associates, practicing physical medicine and rehabilitation, non-operative spine care, and sports medicine. Active in his local community, Palmer mentors health care apprentices, sponsors sports medicine clinics, and is a member of the Mercer County Medical Society.



Jeffrey C.
Goodwin

Serving you better

Phillipsburg's Warren Hospital has plans for an affiliation with the Robert Wood Johnson Health System. Warren Hospital joins the 11-member affiliates of the Robert Wood Johnson Health System.

"This agreement brings to Warren County residents access to the latest research and clinical trials and enhanced patient care opportunities afforded by this strong affiliation with Robert Wood Johnson University Hospital, the Robert Wood Johnson Medical School, and other Robert Wood Johnson Health System groups," notes **Jeffrey C. Goodwin**, president and CEO of Warren Hospital.

Help find the cure

You can help fight cancer. It's easy with the purchase of New Jersey's **Let's Conquer Cancer** specialized license plates. Proceeds from the sale of Let's Conquer Cancer license plates will go to the New Jersey Commission on Cancer Research (NJCCR) to support innovative cancer research projects in the Garden State. NJCCR also administers the New Jersey Breast Cancer Research Fund, which is fueled by a check-off box on the

state income tax return. This is the first time in New Jersey that specialized plates will benefit the health of the citizens and the first plates in the nation to fuel the battle against cancer, says Frederick Cohen, MD. For more information, contact the New Jersey Division of Motor Vehicles at 1/888-486-3339 or NJCCR at 609/633-6552.



Focus on asthma

More than 118,000 Garden State children have asthma, says the American Lung Association. Many children, especially those in medically underserved settings, aren't receiving appropriate care for this chronic problem. A community effort is underway in Passaic to target asthma in

urban children. The initiative will examine the impact of the disease and the number of children affected and then community-friendly asthma management programs will be designed and implemented. The **Passaic Asthma Reduction Effort** program is spearheaded by Passaic Beth Israel Hospital in collaboration

with St. Mary's Hospital, the Passaic Board of Education, the Passaic Health Department, and other local community groups. Funding is provided by a grant from The Robert Wood Johnson Foundation, in Princeton.



continued on page 16

continued from page 15

People in the news



Michael Hotz

Michael Hotz takes over as the administrator of the Kessler Care Center at Great Falls, in Paterson.

Holy Name Hospital has appointed **Robert**

P. Raggi, MD, director of the Department of Anesthesiology.

National osteoporosis expert, **Marjorie M. Luckey, MD**, has been appointed medical director of the Osteoporosis and Metabolic Bone Disease Center, a part of the Saint Barnabas Health Care System.



Robert P. Raggi, MD

New IVF program

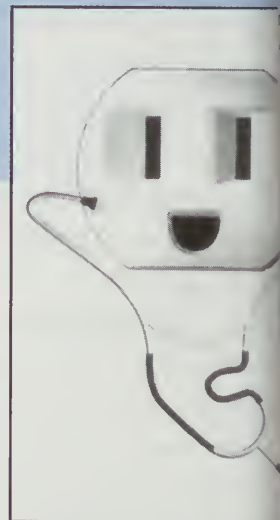
Patients in Ocean and Monmouth Counties now have state-of-the-art in vitro fertilization (IVF) program right around the corner at a neighborhood hospital says MSNJ member Gilbert Wilshire, MD. Previously, many patients were sent to North Jersey or out of state for IVF treatment. Wilshire, and Allen Morgan, MD, are the co-directors of the new Jersey Shore In Vitro Fertilization Program at Jersey Shore Medical Center—the only hospital-based IVF laboratory in Monmouth and Ocean Counties. The program is a partnership between UMDNJ-Robert Wood Johnson Medical School and Jersey Shore Medical Center.



A family tours the new IVF program at Jersey Shore Medical Center.

More money in your pocket

With the help of Energy Star® Program, the American Academy of Otolaryngology-Head and Neck Surgery Foundation saves over \$7,500 annually on energy bills. Wouldn't you like to save that kind of money? The National Association of Physicians for the Environment (NAPE) has designed a health care energy efficiency program, in cooperation with the United States Environmental Protection Agency. Simple efforts to decrease energy bills can significantly reduce medical facility operating costs and contribute to environment protection leading to health promotion and disease prevention. Energy efficiency upgrades in offices and clinics can save 30 to 40 percent on energy costs. For more information, contact NAPE at 6410 Rockledge Drive, Suite 412, Bethesda, MD 20817; telephone 301/571-9790; fax 301/530-8910; or e-mail nape@ix.netcom.com.



H. Colleen Silva, MD

H. Colleen Silva, MD, joins the Jersey City Medical Center as president of the medical staff.

Frank Vozos, MD, assumes the position of executive director of Monmouth Medical Center.

Hackensack University Medical Center named **Garth Hadden Ballantyne, MD**, chief of the Minimally Invasive Surgery Division of the Department of Surgery.



Garth Hadden Ballantyne, MD

East Orange's Kessler Institute for Rehabilitation added **Jonathan Fellus, MD**, to its medical staff.

John Paul Dizzia, P.C. ATTORNEYS AT LAW

Legal Counseling and Representation to Medical Professionals in administrative, regulatory and disciplinary matters before the State Board of Medical Examiners, the Department of Insurance, the Division of Medical Assistance and Health Services, and in the law relating to professional rights, responsibilities, ethics and practice issues.

Member:

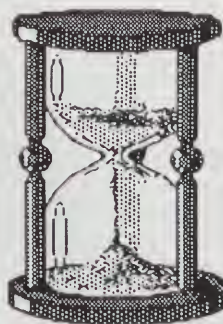
- National Health Lawyers Association
- Health and Hospital Law Section, New Jersey Bar Association
- New Jersey Association of Professional Mediators

North Union Ave.
P.O. Box 886
Manford, N.J. 07016

Call: (908) 276-6111
FAX: (908) 276-5838
E-Mail: JPDLaw@WORLDNET.ATT.NET

TIME.

Staffing,
Hiring, Training,
Phone Etiquette
Billing,
Patient Flow
Insurance,
CPT & ICD Coding,
all take time to
coordinate effectively.
All critical decisions.
Is your staff working
up to expectations?



Do you have coding problems? Call one number for a complete turn-key approach, assuring peak performance in your office. Your medical practice is a business, and if that business does not run efficiently, it will affect your patient and public relations.

YOURS IS VALUABLE.
SAVE IT! REORGANIZE!

MARY ANN HAMBURGER
A S S O C I A T E S

THE SPECIALIST'S SPECIALIST
74 HUDSON AVE. MAPLEWOOD, N.J. 07040
973-763-7394

Lowest Premiums for Quality Malpractice Insurance

Joseph A. Britton Agency can help make it happen. If you are a preferred risk¹, you can qualify for preferred rates². Compare these annual premiums at occurrence limits of \$1,000,000/\$3,000,000:

• Anesthesiologists	\$ 8,572	• Radiologists	\$ 5,331
• General Surgeons	\$18,453	• Plastic Surgeons	\$23,350
• Internists	\$ 5,331	• Psychiatrists w/ect	\$ 2,937
• Ob-Gyns	\$39,000	• Urologists	\$11,993

With more than 25 years of experience, the Britton Agency has proven exceptional in packaging malpractice insurance. Our professional staff and size assure you the benefits of specialized, personal service while offering you insurance at the lowest cost.

Call for a free consultation. Start saving tomorrow.



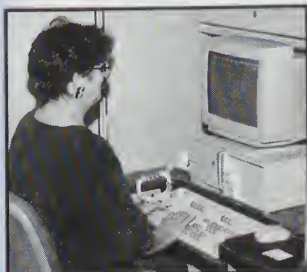
Joseph A. Britton Agency, Inc.
Healthcare & Professional Liability Insurance
855 Mountain Avenue, Mountainside, NJ 07092
(908)654-6464 • Fax: (908)654-1422 • 1(800)462-3401

¹Underwriting approval required. ²May need groups of 3 or more depending on speciality.

ONLINE

MSNJ

Be careful out there



Web users beware. There's lots of borderline journalistic standards, advertorials (a mix of editorial and advertisements), scams, and false data floating in cyberspace. But, there's hope: the web site, Internet Scambusters, exposes scams (www.scambusters.org) and National Fraud Information Center, a web site run by the National Consumers League, reveals fraud (www.fraud.org).

Who is out there?

Health care information seekers, based on Find/SVP, Inc. surveys, are not typical Internet users, says Michael S. Brown, president of MSB Associates. HealthMed Retrievers—as Brown calls them—make up 43 percent of all United States adult Internet users. Who are these people? Their average age is 38; 45 percent of them are college graduates; their average annual household income is \$55,700; most of them are men; and 70 percent are married. The HealthMed Retrievers segment of Internet users can expect robust growth. Look for a 73 percent increase during 1998, says Brown.

Top five subjects accessed by HealthMed Retrievers in 1997

Subject	Percent of HealthMed Retrievers
Alternative medicine	11
Diet and nutrition	11
Women's health	10
Cancer	10
Heart disease	9

Source: Find/SVP, Inc., 1997

In memoriam on the web

The MSNJ web site offers a listing of obituaries of members. Under the section heading, Resources, visitors to the web site (www.msnj.org) can read the In Memoriam section, which is updated weekly. The section notes the name of the physician-member, dates of birth and death, county of membership, medical school, year of graduation, and medical specialty.

Cyberspace members

Web sites are doing more than just doling out information. Many associations and organizations are using the Internet to attract new members. "One of the strongest tools at our disposal to recruit members is our web site, msnj.org," explains MSNJ President Carl Restivo. When a potential member is online with msnj.org, that doctor will quickly see the benefits of membership. The site gives potential members a look at MSNJ and the results MSNJ achieves for New Jersey physicians and health care consumers. "We're pleased with the number of inquiries we get about joining MSNJ that directly stem from the web site," notes JaNoel Bess, MSNJ membership director.



Carl Restivo

Bookmarks

<http://members.aol.com/ncaddnj/>

Take a look at the National Council on Alcoholism and Drug Dependence-New Jersey web site. It was named one of the top ten sites on substance abuse by the 1997 *Guide to Behavioral Health Resources on the Internet*.

www.medconnect.com

Princeton-based Medical Network, Inc. added five online medical journals to its web site: *Managed Solutions*, *iPeds*, *STAT*, *Family Practice Resident*, and *Prime Connection*.

www.dotcomhealth.com

DotCom Health Network is your online guide to Garden State health care providers and resources, such as HMOs, nursing homes, home respiratory care, and assisted living.

www.usp.org/

Physicians and health care practitioners can report medication errors confidentially to the United States Pharmacopeia using its online Medication Errors Reporting Program.





Stuart M. Hochron, M.D., Esq.

Physician Legal Representation

- Group Practice Formation
- Physician Litigation
- Federal Regulation
- Board of Medical Examiners

Practicing Physician, Twenty Years

Clinical Professor, UMDNJ-RWJMS
Research as Highlighted on CNN
AMA Physician Referral Service
Partner, Richmond, Hochron & Burns



phone: (732) 821-0200 fax: (732) 422-9444 e-mail: MDLAWSMH@aol.com

209 North Center Drive North Brunswick, New Jersey 08902

Our medical specialists make a practice of creating solutions for physicians like you.

Summit Bank's Healthcare Financial Services Group features some of the finest medical specialists in New Jersey. They understand your industry and the issues facing it. As New Jersey's largest locally headquartered bank, our professionals are specifically devoted to the healthcare industry. That means our customized solutions — from loans to leases — come with something extra: time-tested expertise. If you'd like, we'll even help you find a more efficient way to run your practice. To find out more, call Norm Buttaci, Regional Vice President, 609-987-3561.



Summit, Summit Bancorp and Reach Higher are registered service marks of Summit Bancorp • Summit Bank is a service mark of Summit Bancorp.

Just the facts, ma'am. Just the facts.

In my January 1998 "Mail Stop" reply to an upset reader, I noted that *U.S. News and World Report* was not my idea of a reputable rating agency. More recently, the Association of American Law Schools also called on that same magazine to cease and desist, saying its rankings were unfair and detrimental to their institution and its students.

What are we to accept? Beliefs, long cherished, are falling by the wayside, and lavish promotions tend to warp objective assessment. Much criticism was given recently to the "Transcatheter Cardiovascular Therapeutics" meetings attended by thousands of physicians, who received everything from shoe shines to computer cases, and who were targeted to recommend various stents, costing \$300 to make, but selling for \$1,500 and up. Fortunately, such meetings are anathema to organizations like the American Heart Association.

Even more pervasive are health care claims trumpeted in the media, often based on some scientific research, but worth considering with skepticism. As Arnold Relman said, "You have to ask how carefully a study has been reviewed, where it comes from, and how does it apply to you. Information is not necessarily fact." Health matters are hot. Television and newspapers

adore them. Truth is not essential; sensationalism is.

When apparently well-designed studies tend to overturn long-established thinking, both physicians and laity become confused. Does a low-fat or a high-fat diet help to prevent stroke? How much alcohol, and what type, is good for the heart and



Howard D. Slobodien, MD

We have much to learn from other sources about quality and delivery of care. Physicians must participate in these processes.

bad for the breast? How much can we rely on animal experiments? A dose of digitalis easily metabolized by a rat could kill a human. Is there meaningful information in the usual study comparing medical and surgical therapies? As Susan L. Crowley reported in the *AARP Bulletin* of February 1998, *The New York Times* said, "Study finds less correlation between fat and early death. The study found the excess risk of dying associated with being fat was relatively modest and declined as people aged." The *Washington Post* carried the news, "Excess weight can be a burden on

longevity and thinner is definitely better at almost all ages, including well into middle age." The original research upon which these newspaper accounts were based was published in *The New England Journal of Medicine*, whose editors wrote, "Until more is known we should remember that the cure [with futile and sometimes dangerous weight-loss

She always says, my lord, that facts are like cows. If you look them in the face hard enough, they generally run away.

Dorothy L. Sayers, *Clouds of Witness*, 1926

Reason deceives us more often than nature. Vauvenargues, *Reflections and Maxims*, 1746

schemes] for obesity may be worse than the condition."

Is it any wonder that alternative medicine flourishes—nay, is being encouraged? Not only does it carry the imprimatur of centuries of satisfactory use, it also prospers because of increasing uncertainty about the underlying value of present-day scientific medicine.

Dr. Jack D. Myers, internist at the University of Pittsburgh, died on January 31, 1998. He developed one of the first computer programs to aid in diagnosis. He graduated to a system for scanning the literature, called Q.M.R., which is used to make medical decisions. Today we have many web locations; one site, <http://hiru.hirunet.mcmaster.ca/ebm/default.htm>, is of historic and practical importance. McMaster University in Canada is considered the ancestral hall of the evidence-based medicine (EBM) movement, and its site teaches one how to use and profit from EBM. A critique of health information areas on the Internet, published in the February 25, 1998, issue of *The Journal of the American Medical Association*, originated with the McMaster group. It warned that much available information is either worthless or dangerous. Once again, caveat emptor!

Nevertheless, there exists a critical need to investigate technology, processes, outcomes, data-processing methods, the social needs of various populations, and the economics associated with them. One of the lead articles in *The New York Times* bemoaned the schism between necessary fertility treatments and insurance coverage, leading to such absurdities as repeated futile, but insured, tubal surgery instead of indicated, but uninsured, in vitro fertilization. Recent studies have found that coverage for advanced reproductive technology would cost less than \$3 per member

per year. Dr. Kenneth J. Ryan, professor emeritus of obstetrics, gynecology, and reproductive biology at Harvard and chair of the ethics committee of the American Society of Reproductive Medicine agreed: "The system as it exists makes no sense."

George J. Annas, well-known head of the health law department at the Boston University School of Public Health, demurs. Not only does he feel these reproductive measures should be elective, but he says, "In fact, people don't have the right to any health care in this country except emergency care," but if we had national health insurance "then we should think about adding this as a benefit." Would someone please tell me why we shouldn't spend \$3 now, but should add the benefit to a program acknowledged to be more expensive than the present one?

Priorities must be developed and refined. They are needed, not just for an Oregon-type Medicaid program, but to understand how to allocate finite resources. The number of the uninsured and the poorly insured escalates. As the *Hastings Center Report* of November-December 1996 recommended, we must set priorities on both the national level and within the health care system itself. We must integrate medical and social welfare services, in their economic, sociocultural, health, and psychological aspects. "We take it as a given that every civilized society should guarantee all of its citizens a decent basic level of health care, regardless of their ability to pay for it."

We have much to learn from other sources, and from other countries, about quality and delivery of care. Physicians must participate actively in these processes and learn to separate the wheat of fact from the chaff of theory. Truth and logic are not synonyms and we must recognize the difference.

When professional health law counsel is called for,
call the firm the experts are calling.



For years health care providers and businesses have been calling Theodosia A. Tamborlane P.C. when they needed accurate information, insightful commentary and practical advice. That's because Theodosia A. Tamborlane P.C. successfully navigates through the maze of government activity at both state and federal levels every day.

Today physicians, hospitals, nursing homes, assisted living, ambulatory care

facilities, home health care agencies and other providers turn to this firm for legal services including managed care contracting and corporate compliance plans. It's little wonder why leading health law publications and the nation's most prestigious legal, medical and business associations keep calling Theodosia A. Tamborlane P.C. to keep their members up to date. When you need professional legal counsel select the firm that knows the issues ...

Theodosia A. Tamborlane, P.C.



THEODOSIA A. TAMBORLANE, P.C.

COUNSELORS AT LAW

1044 ROUTE 22 WEST, MOUNTAINSIDE, NEW JERSEY 07092

908-789-7977

Member, American Medical Association Doctors Advisory Network

Charter Member, American Association of Physician-Hospital Organizations-Integrated Healthcare Delivery Systems

LIFSHUTZ, POLLAND & ASSOCIATES, P.C.

THE LAW FIRM THAT SPECIALIZES IN HEALTH
CARE REPRESENTATION OF PHYSICIANS AND
OTHER HEALTH CARE PROFESSIONALS.
OUR AREAS OF EXPERTISE INCLUDE:

1. Managed Care Contracts with MSOs and HMOs.
2. Health Care Mergers/Joint Ventures/Acquisitions.
3. Development and implementation of Compliance Audits and Plans.
4. Respresentations in Board of Medical Examiner Cases.
5. Asset Protection/Estate Planning as protection against malpractice suits.
6. Federal and State Anti-Kickbacks/Stark/Safe Harbor representation.
7. Medicare/Medicaid/Third Part Audits

OUR EXPERT STAFF CONSISTS OF SPECIALIZED
ATTORNEYS AS WELL AS PHYSICIAN-ATTORNEYS.

LIFSHUTZ, POLLAND & ASSOCIATES, P.C.

ATTORNEYS AT LAW

326 LAFAYETTE AVE., HAWTHORNE, NJ 07506
(201) 427-2040

675 THIRD AVENUE, NEW YORK, NY 10017
(212) 949-8484

Web: Lifshutz-Polland.com

The Medical Manager

Practice Management Software

A fully integrated practice management solution

Over 16 years' experience in providing
healthcare automation solutions

Provides an open system architecture
and flexibility for specialized needs

Designed for small group practices to large
Integrated Delivery Systems

Overwhelming national presence

Learn more about how Medical Manager Corporation and
The Medical Manager system can meet your needs. Contact us
at 800.677.7784, 201.808.0088, or www.medicalmanager.com.

Medical Manager

Corporation

RTL, Inc. and Medix

Empowering the Industry Through Partnership

NEW YEAR. NEW RULES.

Have you analyzed all your new IRA options?

Let the T. Rowe Price IRA Analyzer™ show you how. The new T. Rowe Price IRA Analyzer software provides you with a detailed description of the new IRA rules in plain, straightforward language. This sophisticated tool is easy to use and will help you assess:

- How much you are eligible to contribute to each type of IRA;
- Whether it would be more beneficial to make future contributions to a Roth IRA or a Traditional IRA;
- If you should convert your existing IRA to the Roth IRA.

Our Analyzer does it all on your PC—making your analysis more accurate and rapid. The software includes advanced features that will calculate your maximum eligible contributions to each type of IRA, incorporate the impact of minimum required distributions at age 70½, and allow for full or partial conversions to the Roth IRA.



Order your IRA Analyzer today for only \$9.95, and start taking advantage of the new IRA rules. Call: 1-800-831-1379

Visit our Web site for free interactive
IRA worksheets.

www.troweprice.com/newira/

Software available on both CD and diskette. Available for PCs only.

Invest With Confidence®
T.RowePrice



To run the T. Rowe Price IRA Analyzer, you need an IBM®-compatible running Windows® 3.1 or above. A 486 processor or greater is recommended. You also need 4 MB free space and 8 MB of RAM. A VGA monitor with 256-color or better video card is required.

T. Rowe Price is a registered trademark of T. Rowe Price Associates, Inc., and other trademarks are property of their respective owners.

T. Rowe Price Investment Services, Inc.

IRA0

UNIVERSAL HEALTH CARE IS ESSENTIAL

James Florio

Mr. Florio is the former governor of New Jersey and chair, The Florio Group, a business-consulting organization.

Just-released reports about health care in New York state should be a cause of concern for the United States. The studies, issued by private philanthropic organizations, conclude that the number of citizens in New York without health insurance is growing dramatically. In 1991, 13.9 percent, or 2.2 million New Yorkers under age 65, lacked coverage. By 1996, the number had risen to 19.1 percent, or 3.1 million people.

The studies highlight the dirty little secret of national health care policy; Americans are losing access to health insurance in record numbers, even as the U.S. economy booms.

In 1993, 37 million Americans lacked health insurance. Currently, anywhere from 42 to 44 million people have

no coverage. That means at least one million people a year have entered the ranks of the uninsured in the last five years. The newly uninsured are not slackers. It is estimated that 23 million, or about one-half of the

the working uninsured earn less than \$10.30 per hour.

As the workplace changes, this problem is expected to worsen. As companies try to increase competitiveness by cutting costs, they will expand practices that will reduce insurance coverage availability:

- Outsourcing of job functions to companies that do not provide insurance.
- Development of two-tier wage structures, with the lower tier having less or no coverage.
- Increases in employee copayments or deductibles.
- Reductions or cancellations of insurance

for retirees younger than 65, who relied on promised retirement coverage.

- Reduced percentages of unionized contracts.
- Greater use of contingent workers, who rarely get health-care coverage.

The practices, as well as layoffs with the loss of job-con-



uninsured, work. Presumably, most of the balance are children. They are not old enough to be on Medicare or poor enough to be on Medicaid. They are people who do not work for firms that provide health insurance and who do not earn enough to buy it themselves. A U.S. Senate committee concluded that two-thirds of

A universal health care system, in which all Americans get good care, is not only the right thing for the wealthiest nation on earth, it is a smart, cost-effective policy.

nected health benefits when the economy slows, mean health care will be back as a front-burner issue.

The burgeoning economy of the last few years, with its great job growth, masked the fact that a large portion of those jobs did not come with health insurance coverage. Likewise, as costs start once again to go up as anticipated, even under managed care plans, we can foresee employers reducing the scope of coverage, or shifting more of the costs to employees, or both.

The tragedy of the health policy debate in Washington is that it has focused on but two of the three components of what is truly needed—cost and quality—but not access. When the cost of the system in the 1980s and early 1990s became so oppressive so as to impair our economy's competitiveness, we took action. The private sector led the way in moving to managed care cost-containment programs. HMOs and insurance companies

sought, through "gatekeepers" and other control devices, to reduce unneeded practices and expenses. The initial results reduced costs.

The policy pendulum now has swung to a national preoc-

ability of purchasers of insurance to control costs.

This ping-pong approach to policy involving costs versus quality ignores the issue of access, which can have a direct effect on cost and quality.

A universal health care insurance system, in which all Americans get good care, is not only the right thing for the wealthiest nation on earth, it is a smart, cost-effective policy. How to achieve that goal is subject to legitimate debate involving the public, private, and for-profit sectors, or most probably some combination of all three. It is essential, however, that we conduct that debate on realistic, comprehensive terms, leaving no one excluded from the system, much less 44 million Americans.

Reprinted from *The Home News*, 1998.

Editor's note. Governor Florio and I are on the same wavelength. I recommend critical analysis of the last paragraph, which suggests a fairly "American" way to answer this escalating problem.



cupation with a perceived loss of quality care, to the point that the president, with bipartisan support, is advocating a health care Consumers Bill of Rights, which would set national standards for health insurance. Opponents maintain that such a course of action would escalate prices by undermining the

NOMINATING COMMITTEE REPORT

Anthony P. Caggiano, Jr, MD

MSNJ 1998 Annual Meeting

Office	Term	Nominee and County
President-Elect	1 year	Irving P. Ratner, MD, Burlington
1st Vice-President	1 year	Walter J. Kahn, MD, Monmouth
2nd Vice-President	1 year	Angelo S. Agro, MD, Camden
Secretary	3 years	Bessie M. Sullivan, MD, Union
Treasurer	3 years	Eileen M. Moynihnan, MD, Camden
Trustees*		
1st District		Mark T. Olesnick, MD, Essex
2nd District		Robert S. Rigolosi, MD, Bergen
5th District		Churchill L. Blakey, MD, Gloucester
Judicial Councilors		
2nd District		Edwin M. Trayner, MD, Bergen
5th District		Gastone A. Milano, MD, Atlantic
AMA Delegates		
	2 years	George T. Hare, MD, Camden
	2 years	Harry M. Carnes, MD, Camden
	2 years	Donald J. Holtzman, MD, Union
	2 years	Walter J. Kahn, MD, Monmouth
	2 years	Patricia G. Klein, MD, Bergen
	2 years	Irving P. Ratner, MD, Burlington
	2 years	Carl Restivo, Jr, MD, Hudson
	2 years	Robert J. Weierman, MD, Essex
AMA Alternate Delegates		
	2 years	S. Manzoor Abidi, MD, Burlington
	2 years	Angelo S. Agro, MD, Camden
	2 years	Michael H. Bernstein, MD, Passaic
	2 years	Charles M. Moss, MD, Bergen
	2 years	Joseph H. Reichman, MD, Camden
	2 years	John W. Spurlock, MD, Hunterdon
Administrative Councils		
Communications		
1st District	2 years	Anthony Del Gaizo, MD, Essex
2nd District	2 years	Sandra S. Valdez, MD, Hudson
3rd District	2 years	Ismail Kazem, MD, Mercer

membership MATTERS

4th District	2 years
Member-at-Large	2 years
Member-at-Large	2 years
Member-at-Large	2 years

M. Arif Hashmi, MD, Camden
 Paul J. Carniol, MD, Union
 Niranjana V. Rao, MD, Middlesex
 Richard A. Williams, MD, Hudson

Legislation

1st District	2 years
2nd District	2 years
3rd District	2 years
4th District	2 years
5th District	2 years
Member-at-Large	2 years

Alan J. Lippman, MD, Essex
 Paul V. Cavalli, MD, Hudson
 Javier G. Taboada, MD, Mercer
 Mary F. Campagnolo, MD,
 Burlington
 Satish P. Shah, MD, Salem
 Austin H. Kutscher, Jr, MD,
 Hunterdon

Medical Services

1st District	2 years
2nd District	2 years
3rd District	2 years
4th District	2 years
5th District	2 years
Member-at-Large	2 years

Franklin A. Morrow, MD, Union
 Ramesh C. Tandon, MD, Passaic
 Porfirio A. Mariano, MD, Mercer
 No candidate
 Richard A. Menghetti, MD, Atlantic
 No candidate

Public Health

1st District	2 years
2nd District	2 years
3rd District	2 years
4th District	2 years
Member-at-Large	2 years

Peter Blumenthal, MD, Essex
 Laurene DiPasquale, MD, Bergen
 Anthony J. Ricketti, MD, Mercer
 J. Mark Meredith, MD, Burlington
 Anne C. Brouard, MD, Morris

Standing Committees

Annual Meeting

2 years
2 years

Nancy L. Mueller, MD, Bergen
 Edwin M. Trayner, MD, Bergen

Finance and Budget

2 years
2 years

William L. Diehl, MD, Morris
 No candidate

Medical Education

2 years
2 years

Robert A. Fuhrman, MD, Union
 Eric Munoz, MD, Essex

*An additional at-large Trustee will be added to the Board of Trustees in 1998. This at-large Trustee is not subject to the Nominating Committee process, since the county will not be determined until after the regular process.

Direct AccessSM

for small employers from



BlueCross BlueShield
of New Jersey

is here!



Visit a specialist without a referral.

Pay **\$0** for all your office visits.

Receive nationwide access to practitioners. Over 300,000 doctors, specialists and hospitals participate.

Receive value added discounts for you and your employees from Cole Vision and CompUSA.

And, receive a very attractive rate!

And more is available when you choose the new Direct Access health plan from Blue Cross and Blue Shield of New Jersey—The Medical Society of New Jersey's health carrier of choice for its members' insurance!



BlueCross BlueShield
of New Jersey

INDIVIDUAL &
SMALL EMPLOYER
DIVISION

Ask us for a free
copy of the SEH
Buyer's Guide.

For more information on Direct Access, and all other health plans for individuals, families and small employers, contact the Medical Society of New Jersey's exclusive BCBSNJ representative:

Medical Society of New Jersey
MSNJ

Jennifer Altobelli
Sales Representative
973-338-0893



HEALTH LAW PRACTICE

*representing healthcare providers,
including physicians, physician groups, other
clinical professionals, academic medical
centers, multihospital systems, independent
acute care and specialty care hospitals,
ambulatory care centers, and nursing and
assisted living facilities*

For more information or a copy of our
New Jersey Health Law Advisory,
please contact
Alma L. Saravia
51 Haddonfield Road
Cherry Hill, NJ 08002 • (609) 488-7300

DUANE, MORRIS & HECKSCHER LLP

A PENNSYLVANIA LIMITED LIABILITY PARTNERSHIP

Cherry Hill and Newark, New Jersey
with additional offices in
Pennsylvania • New York • Washington, D.C.
Delaware • Florida

You take care of your patients. We'll take care of the health of your practice. Our group of health care accounting specialists provides the medical community with the right type of analysis and counseling to be successful.

Since we're dedicated to increasing your profitability, never simply reporting it, we'll see

to it that your practice stays healthy for many years to come. To experience our unique approach, please call Ira S. Rosenbloom, Managing Director, at 973-882-1100.

PRACTICE GOOD FINANCIAL MEDICINE.



Mintz Rosenfeld & Company LLC

Profitability Consultants • Certified Public Accountants
60 Route 46 East, Fairfield, NJ 07004
Tel: 973-882-1100 Fax: 973-882-1560

OUR FOCUS IS YOUR SUCCESS.

You didn't build your reputation just so your insurance company could destroy it.

How your insurance provider handles malpractice suits can have a critical impact on your future. Many insurance companies will make little effort to defend you against lawsuits, preferring instead to settle. In those cases, the claim becomes part of your resume forever, and may affect your future. As you know, it's common practice for managed care organizations to deny participation due to past malpractice claims, including out-of-court settlements.

Consider instead the comprehensive services of B.C. Szerlip. We offer 60 years of experience providing top-quality insurance services to physicians and surgeons. We represent only "A" rated insurance companies who provide superior legal defense. Almost 70% of lawsuits against our customers are dropped. Our expert legal defense team wins more than 80% of the remaining cases. So there's almost never a loss or settlement to put a dent in your hard-earned reputation.

Due to the loyalty of our customers, B.C. Szerlip has achieved unparalleled financial stability. No matter when a claim is filed, we'll be here to defend you.

To give you a taste of our full-service approach, we'd like to send you a fascinating booklet, *The Managed Care Survival Kit for Physicians*. To receive your own obligation-free copy, please call us at 800-684-0876.

BCSZERLIP

INSURANCE AGENCY INC.

99 WOOD AVENUE SOUTH, PO BOX 217
ISELIN, NJ 08830-0217
800-684-0876 • 732-205-9800
FAX: 732-205-9496
E-MAIL: bcszerlip@aol.com

*Professional Insurance Services
for Health Care Providers*

Bill Berlin, PhD

INTERVIEW WITH CHARLOTTE VANDERVALK

Assemblywoman Vandervalk is chair, Assembly Health Committee, and is a member of the Senior Issues and Community Services Committee, the Joint Legislative Task Force on Biotechnology, the Joint Legislative Task Force on Software Technology, and the Governor's Task Force on Welfare Reform. Vandervalk has served on the Assembly Consumer Affairs and Regulated Professions Committee as vice-chair, on the Assembly Community Services Committee, as Assembly assistant majority leader, and on the Assembly Financial Institutions Committee as vice-chair.

A community service volunteer, Vandervalk serves the Montvale Education Foundation and the New Jersey Friendship House, and is affiliated with numerous Bergen County organizations.

Q. Last year was a very active year with respect to health legislation and managed care, in particular. What was the highlight of the year?

A. The Health Care Quality Act was the result of a great deal of deliberation and consensus. I feel that we have a good, substantial bill. What we want to do now is watch and monitor, and make sure that there really are protections. So while I wouldn't rule anything out completely, I'm reluctant to jump into any further changes.

Q. The managed care regulations included new appeals procedures. How can these be enforced without increasing costs?

A. With the law in place, the New Jersey Department of Health and Senior Services has the ability to increase fines, which could increase revenues. But over and above that, we're going to get a very clear picture from what happens on the appeals panels. We always get feedback from the public, mail, telephone calls, and media reports. So the public will help us monitor this, as they have done in the past.

Q. How much do you think the public knows at this point about the new regulations?

A. We have a challenge to get that information to the public. The whole health care system now is so complex, and there have been so many

changes, that the public is confused and professionals are confused.

The next step is to encourage Congress to follow the lead that we have taken in New Jersey. There's a big missing piece in that state laws do not cover people in the self-insured plans. This could be corrected by federal legislation that would create a level playing field. As legislators, we don't want to deal over and over again with what has been referred to rather crassly as "body parts" legislation. We want to see a system in place that puts doctors and patients in charge of health care.

Q. Was there a public education component built into the health care legislation?

A. As part of the legislation, people's rights are to be clearly spelled out in the information they receive from insurance companies. We tried to standardize this requirement so that people would see what type of a policy they were purchasing.

Q. It seems as if there are two opposite trends at work

today: less regulation in the area of hospitals and more regulation when it comes to managed care.

A. Yes, I think that's a fair way to put it. Our basic goal is to put physicians and patients in charge of health care and to take insurers out of these decisions. We're really trying to create a level playing field and a competitive environment to bring about improvements in the system, and that's not easy.

Q. What do you see on the agenda for 1998?

A. We are going to continue to get complaints about the current system. We will have to evaluate whether these complaints can be covered by the Health Care Quality Act, or whether we're going to have to go further. I don't think there will be a rush to go further until we come to terms with the current law.



Assemblywoman Charlotte Vandervalk

I think it's important for the Health Committee to get involved in public hearings on various issues—for example, the pharmaceutical industry. In some respects, there's important public information there for consumers. You don't know until you have a public hearing what kind of information will come forth. Certainly, cloning has become an important public issue, and I expect we will have a public hearing on that issue. While I believe that human cloning should be banned, we need expert guidance to suggest some of the other issues we should consider.

Q. Do you think there might be greater efforts in the legislature to protect patient confidentiality?

A. Yes, as electronic information becomes more important, I have very strong concerns about protecting the privacy of the patient. Assemblyman Nicholas Felice and I have introduced legislation that would deal with that issue. It's been on the back burner for awhile, but I expect that this is the year it will come to the forefront.

Q. Looking at broad trends, one of the issues the state will have to deal with is an aging population. Do you see the Legislature taking any action in this regard?

A. I've sponsored a piece of legislation called the Program of All-Inclusive Care for the Elderly (PACE). Essentially, this bill would provide greater choice by allowing the senior citizen to live more independently, and the bill also combines this choice with a savings program.

I passed two bills last year dealing with pain management,

and that's an issue I continue to feel very strongly about; this issue does not receive enough attention. I am just appalled that we are approaching the turn-of-the-century and so many people, especially the elderly, are living and dying with chronic pain. It is so unnecessary, and yet there are many obstacles. One bill created the Pain Management Study Commission to see how we can move forward.

Q. Will the Pain Management Study Commission look at palliative care and end-of-life issues?

A. If you talk to people who are involved in pain management, you discover that it's a very interesting scene out there. There are ways in which they can keep people free from pain, yet there are obstacles with which to deal. One problem is that patients are afraid of addiction, which should not occur if they are being treated appropriately. Another concern is that physicians fear being accused of over-prescribing drugs.

Q. As a legislator today, how do you read what your constituents want regarding health care? What do you hear from them in terms of their major concerns?

A. For the most part, we hear about individual circumstances—a problem they, a relative, or a friend might have. Sometimes we hear about problems with the health care system after they have occurred, because the constituents want to make sure that no one else is affected. I also read my mail and take it very seriously. This is a great source of information for legislators, because that's how we find out what's really going on out there.

Q. With the rapid changes in health care today, do people seem very confused?

A. The system is very complex, and the minute you think you understand it, something new is happening, and the situation changes. Again, I get back to the need for citizens and legislators to continuously monitor the system.

Ever wish your broker, your trust officer
and your banker had more in common?



A single vision of your future, for example?

As a physician, you spend a lot of time serving your patients and managing your practice. Where do you find the time to manage the people who manage your financial affairs? At PNC Private Bank, the team of people that manage your financial affairs can be just that: a team. People who work together, with a common goal: to realize your vision of the future. PNC Private Bank brings together under

one roof every service you need, backed by 150 years of professional money management experience and the resources of one of the country's largest financial institutions. No conflicts of interest. No misinterpretations. Just the synergy that can only come when everyone who works with you works with each other as well. Call 1-888-844-1565 to learn more about the difference at PNC Private Bank.

PNC PRIVATE BANK_{SM}

Visit us on the World Wide Web. Our address is <http://www.pncbank.com>

Investments • Trusts • Banking Services

PNC Private Bank is a service mark of PNC Bank Corp. Banking and trust services are provided: by PNC Bank, National Association in Pennsylvania, New Jersey, Kentucky, Ohio and Indiana; by PNC Bank, New England in Massachusetts and Connecticut; by PNC Bank, Delaware in Delaware; and by PNC Bank, FSB in Florida. Members FDIC. Brokerage services are offered through PNC Brokerage Corp, a registered broker-dealer and member SIPC. PNC Brokerage Corp is a subsidiary of PNC Bank, National Association, which is not a broker-dealer.

Blood you can bank on

Sheila Smith Noonan

Blood banks have taken a roller coaster ride in public opinion over the past 20 years, from high confidence in the blood supply's safety to low levels of trust. People's fear of contracting infectious disease through transfusions, namely HIV, was widespread in the mid- to late 1980s. Now, with improved testing, sophisticated computer programs designed to bypass human error, and intense public education campaigns, blood banks continue their efforts to stay on track.

In New Jersey, that includes being regulated by the state Department of Health and Senior Services. Only blood banks licensed to send blood across state lines must report mistakes to the Food and Drug Administration (FDA), which asks the other blood banks for



Dr. S.I. Shahied

voluntary disclosure of errors. However, all licensed blood banks in New Jersey are required by state regulation to report all errors related to collection and transfusion of blood. Aside from that, each state determines whether and how it will supervise blood banks within its borders. The Garden State is one of a handful of states that regulates blood banks and has done so since 1963.

All of New Jersey's 170 licensed blood banks are inspected, but unlike scheduled reviews by such accrediting agencies as the College of American Pathologists, the American Association of Blood Banks, and the Joint

Commission of Accrediting Hospital Organizations, these inspections are unannounced, according to Marilou Mallada, one of two blood bank evaluators/inspectors with the state's Blood Banking Clinical Laboratory Improvement Services. Blood banks can be cited and fined for deficiencies that include improper labeling of blood units, unacceptable storage of blood and blood components, and poor recordkeeping. From 1992 to 1996, the state collected \$41,000 in fines.

Blood banks are given the opportunity to correct deficiencies, but if problems remain, the state can revoke licenses and shut them down. Such was the case with the Camden-based Community Blood Bank of Southern New Jersey. When the state inspected the facility in 1990, several serious violations were found, the most egregious being the dispersion of tainted blood and blood components. According to Mallada, one patient was transfused with HIV-infected blood; one HIV-contam-

inated unit was sold as plasma; three plasma units tested positive for surrogate-based hepatitis; and another unit that tested positive for HIV was recalled from a hospital. Those problems, along with the failure to maintain an acceptable internal donor referral list, questionable recordkeeping, inadequate storage, poor training, and unacceptable procedures and policies led the state to close the blood bank in 1991.

The state's blood bank regulations cover reporting requirements; licensing; personnel; facilities, equipment, and contaminated material; criteria for donor selection (including AIDS screening requirements); collection of blood; recipient blood testing; blood storage; and out-of-hospital transfusions. Blood banks must file requests and protocols for such techniques as autologous collection/transfusion; directed donations; plasmapheresis; and cytapheresis. Dr. S.I. Shahied, director of Blood Banking Clinical Laboratory Improvement Services, says a task force is studying the possibility of regulations regarding blood stem cells.

Eric M. Senaldi, MD, medical director of The Blood Center of New Jersey in East Orange, believes the state's role is important—and at times, innovative. “While the FDA provides a broad overview, the state regulates areas, such as out-of-hospital transfusion services, therapeutic apheresis, and in the near future, stem cell collections,” he says. “I’d say that New Jersey probably is on the cutting edge.”

When the public was jittery about the general blood supply, legislators passed the Blood Safety Act of 1991. This law requires surgeons to inform patients that, barring emergencies or contraindications,

they may pre-donate their blood or choose their blood donors. Overall, says Michael Wile, MD, a pathologist and director of transfusion services at Monmouth Medical Center, the law is good public policy that reflects “wonderful advances in transfusion medicine.”

“However, it needs to be applied judiciously,” he says. “The law’s wording is so vague that it applies to even the most minor of surgeries. For a patient getting a hangnail removed, the risk of donating blood

may be greater than the benefits received. And in many cases, self-donations are not used and then must be discarded.”

And blood is a resource too precious to waste, especially with state statistics showing red cell donations decreased in 1996 for the fifth consecutive year. Donations are down 20 percent from 1992, and the New Jersey Red Cross dropped from a blood surplus in the early 1990s to a deficit of 11,503 units in 1996.



Eric M. Senaldi, MD

Despite this downward trend, Shahied says there is no immediate cause for alarm. “This decrease mostly affects our supply of rare blood types, but we have not faced any crises and have been successful in getting the units we need from other states,” he says. “It’s a problem we talk about with blood banks frequently. What can we do to increase donations? How can we do it?”

It may be that blood banks are victims of a changing corporate culture, decreasing membership levels in fraternal organizations, and an increasingly mobile society. Judy Knecht Daniels, public relations director of The Blood Center of New Jersey, believes, “Recruitment is difficult. Older teens are an ideal

group to approach, but it's tough to get them interested. Even if established donors gave blood twice each year instead of once, that would add significantly to the blood supply."

Some people apparently do not donate because of safety concerns, despite scientific evidence to the contrary. In an AABB survey of non-donors, one-third said they did not give blood because of fear of contracting AIDS through donation. This misconception and others still exist, notwithstanding the numerous public education campaigns launched by governmental and private organizations.

Yet the blood supply is far safer than it was in the 1980s; the likelihood of becoming infected with HIV through blood transfusion is estimated at between 1 in 450,000 and 1 in 660,000. There are many reasons for this, blood bankers say, beginning with the donor selection process. Donors are screened more thoroughly for at-risk behavior, and may be disqualified or deferred from giving blood at any time during the collection and testing process. Also accounting for the safer blood supply are new tests with improved sensitivity or specificity; every unit of donated blood now undergoes eight tests for infectious diseases. Computerized blood banking has been credited with eliminating human errors. Senaldi noted that information about each donated unit of blood is computerized and goes through various algorithms to determine whether it can be released. Before live implementation of a computer system, it undergoes validation for six and eight months to ensure that they are operating properly.

As safe as the blood supply is said to be, Wile, who dispenses blood at Monmouth Medical Center, maintains that the safest transfusion may be no transfusion. Indeed, some estimates indicate one-

quarter of U.S. transfusions are superfluous. "I don't want to give out blood unless it's absolutely necessary. Essentially, my goal is to put myself out of business."

While that won't happen, Wile hopes to curb unnecessary transfusions. To that end, he has developed a computerized system that calculates what he calls transfusion practice ratios. With these ratios, Wile can generate mean transfusion figures specific to each department. Doctors can determine how they compare with their peers in terms of the num-

ber of transfusions they are ordering.

"This eliminates finger pointing at specific doctors, which can lead to bad feelings," says Wile. "Instead, doctors within a department can compare their transfusion results against their peers and draw their own conclusions. I'm not saying the system is perfect—there is potential for it to become more sophisticated—but I'm very happy with it."

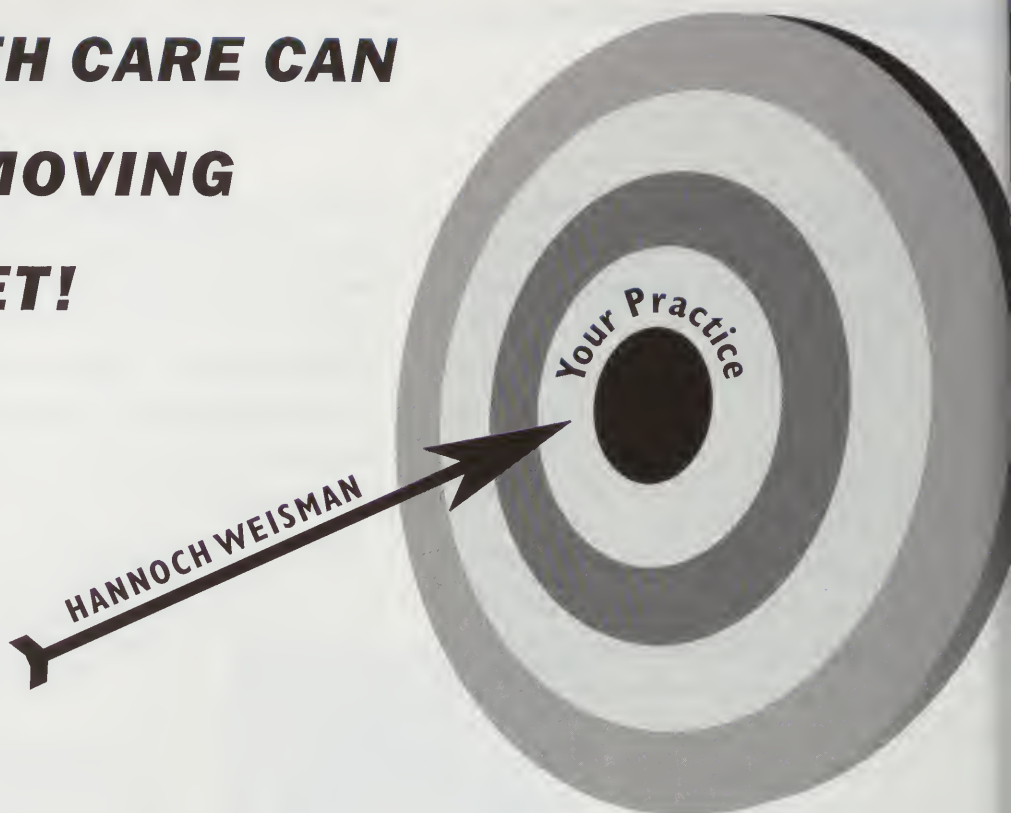


Michael Wile, MD

And Wile is not alone in his desire to curb the number of transfusions. Centers such as the New Jersey Institute for the Advancement of Bloodless Medicine and Surgery, located at Englewood Hospital, use a variety of methods to circumvent transfusion. These include drugs and dietary measures to increase patients' blood counts before surgery; reducing the amount of blood drawn for presurgical testing; devices and techniques to minimize bleeding during surgery; and the recycling of lost blood for return to the patient's body. There is no consensus as to how much these techniques can reduce the need for transfusions, but surgeons are increasingly interested in keeping their blood bank withdrawals to a minimum.

NJM

HEALTH CARE CAN BE A MOVING TARGET!



WHEN YOU CAN'T AFFORD TO MISS . . .

**HANNOCH WEISMAN HAS A RECORD OF HITTING
THE MARK WHEN ADVISING PHYSICIANS ON:**

- ✓ Practice formation, management and operations
- ✓ Review and negotiation of managed care contracts
- ✓ Corporate transactions including mergers and acquisitions and joint ventures
- ✓ Licensing, peer review and disciplinary matters
- ✓ Professional liability and risk management
- ✓ Governmental and payor inquiries and investigations
- ✓ Medical staff relations and credentialing
- ✓ Employee relations and benefits

For assistance or information contact:

Lisa D. Taylor, Esq.

James J. Shrager, Esq.

Hannoch Weisman, A Professional Corporation
4 Becker Farm Road, Roseland, NJ 07068
973-535-5300

TRENDS

Jane E. Miller, PhD
Barbara C. Mundo

Dr. Miller is affiliated with the Institute for Health, Health Care Policy and Aging Research, Rutgers University. Ms. Mundo is associated with the Department of Urban Studies and Community Health, Edward J. Blustein School of Planning and Public Policy, Rutgers University.

From its first appearance in the early 1980s until mid-1996, over one-half million people in the United States contracted AIDS and many more were infected with the human immunodeficiency virus (HIV).¹ By 1994, AIDS ranked as the eighth leading cause of death overall and was the leading cause of death among persons ages 25 to 44 years.² Recent estimates indicate that although the number of AIDS cases among adolescents is relatively small, up to one-half of all AIDS cases are contracted before age 25.³

Because prevention remains the only effective intervention for AIDS, education is critical.

WHAT DO NEW JERSEY ADOLESCENTS KNOW ABOUT AIDS?

Although knowledge of the disease and how to prevent it do not assure appropriate behavioral change, it is unlikely that such change will occur in the absence of accurate information about AIDS and the modes of HIV transmission.⁴ The most common ways AIDS is transmitted among young adults are sexual contact and sharing of intravenous (IV) needles.⁵ The teen years and early 20s are the ages at which most people become sexually active; hence, it is particularly important to convey accurate information about safe sexual practices so that these behaviors can be adopted early. Because most drug use also begins in this age range, early education about risky behavior is essential.^{3,6}

We undertook a school-based survey of AIDS knowledge and sources of information among adolescents in two moderate to high AIDS risk counties in New Jersey.⁷ The objectives of the study were to identify the aspects of AIDS that were not well understood, to assess whether there were differences in knowledge levels according to age, sex, race,

socioeconomic status, or language of the respondent, and to identify the most common sources of information from which adolescents learned about AIDS. Few studies have compared AIDS knowledge levels for English and non-English speaking teens. Insight into patterns of AIDS knowledge by language spoken at home can provide important information on the extent of cultural and linguistic barriers to acquiring AIDS information.

Data and methods. In the fall of 1996, members of the public health program at Rutgers University conducted a survey of 495 8th, 10th, and 12th graders in six public, private, and Catholic schools in Middlesex and Hudson Counties. Between 84 and 91 percent of students in the selected classrooms completed the survey. Subjects were given a two-page, self-administered questionnaire available in English and Spanish and adapted from the 1992 Health Interview Survey.⁸

Results: Composition of the sample. Table 1 presents the demographic composition of the study sample by county,

Table 1. Demographic characteristics of the study sample and target population, New Jersey (percent).

	Middlesex County			Hudson County	
	Study sample	Target population ¹	Study Sample	Target population ¹ County	Target population Town
<u>Race</u>					
Non-Hispanic White	45.9	77.3	10.6	47.7	23.7
Non-Hispanic Black	21.0	7.7	1.5	12.7	1.2
Hispanic	7.2	8.3	79.4	32.8	73.0
Other	25.9	6.7	25.9	6.8	2.1
<u>Language²</u>					
English	81.8	77.0	35.0	51.9	10.1
Spanish	3.4	10.4	61.0	43.0	77.9
Other	14.8	12.6	4.0	5.1	12.0
<u>Educational attainment³</u>					
<high school	4.2	20.6	21.6	35.9	50.1
= high school	17.1	32.1	37.7	28.3	22.9
> high school	78.8	47.3	40.7	35.8	28.0
<u>Poverty rate⁴</u>					
	NA	5.3	NA	11.8	21.5
Total number	293	67,741	200	52,656	3,800

Notes

1 Data on target population from 1990 Census of Population for persons aged 7-12 years in 1990, U.S. Department of Commerce, Bureau of the Census.

2 Language spoken most often at home.

3 For study sample, refers to educational attainment of subject's mother. For target population, refers to educational attainment of all persons age 25 and older in the specified geographic area.

4 Poverty rate is calculated for all households with children under age 18.

along with information on the characteristics of persons aged 13 to 19 years in 1996 for the two target counties based on the 1990 Census of Population.

Hudson County has a higher proportion of non-English

speaking (mostly Spanish) persons, people of non-white race, and households in poverty than Middlesex County. Concentrations of these traits were even greater in the target city within Hudson County. In both counties, the sample has a smaller

share of non-Hispanic whites and non-Hispanic blacks compared to the county as a whole, although the share of non-Hispanic blacks is comparable in the Hudson sample and target city. Persons who speak English as their predominant

language also are over-represented in the sample. The low representation of minority racial and language groups in the Middlesex County sample is due to the fact that urban schools are under-represented in that county. The sample appears to significantly over-represent persons with more than a high school education at the expense of persons who did not complete high school. However, the Census figures probably overstate the latter because many persons in the Census figures (persons age 25 and older) are too old to have high school-aged children, and older persons are more likely to have lower educational attainment. These compositional differences between the sample and target populations also reflect the fact that the study was school based, resulting in the exclusion of out-of-school adolescents. School dropouts typically have a higher than average share of minority racial and ethnic groups and persons of lower socioeconomic status.

Results. AIDS knowledge. Most subjects had a good grasp of general facts about AIDS, correctly answering on average, six of the seven general knowledge questions. Virtually everyone surveyed

Table 2. Sources of AIDS information reported by adolescents (%), New Jersey, 1996 (n=493).

	Percent of students reporting
In the past year, have you:	
Seen any public service announcements about AIDS on television?	90.6
Heard any public service announcements about AIDS on the radio?	66.1
Had instruction about AIDS in school (e.g. health or science class)?	77.2
Discussed AIDS with your parent(s) or guardian(s)?	54.1
From what other sources have you learned about AIDS? (List as many as apply.)	
<u>"Formal" source</u>	74.8
Newspapers/magazines	33.9
School (e.g. teachers, health or other class, coaches, counselors, DARE program)	26.8
Books (e.g. textbooks, encyclopedia, storybooks)	21.7
Television (e.g. documentary, commercials, interviews)	21.3
Medical provider (e.g. doctor, hospital)	9.5
Community organization (e.g. clubs, church, police)	6.7
Brochures or pamphlets	6.1
Radio	5.7
Billboard, sign, poster, or other public display	4.7
AIDS hotline	<1.0
<u>"Informal" source</u>	52.3
Friends or peers	32.5
Parent/guardian or other adult relative	18.1
Movies or videos	7.5
People who have AIDS	4.4
Sibling or cousin	3.7
Computer or Internet	2.4
Music (e.g. songs, rappers, MTV)	2.2
<u>Other source</u>	10.1

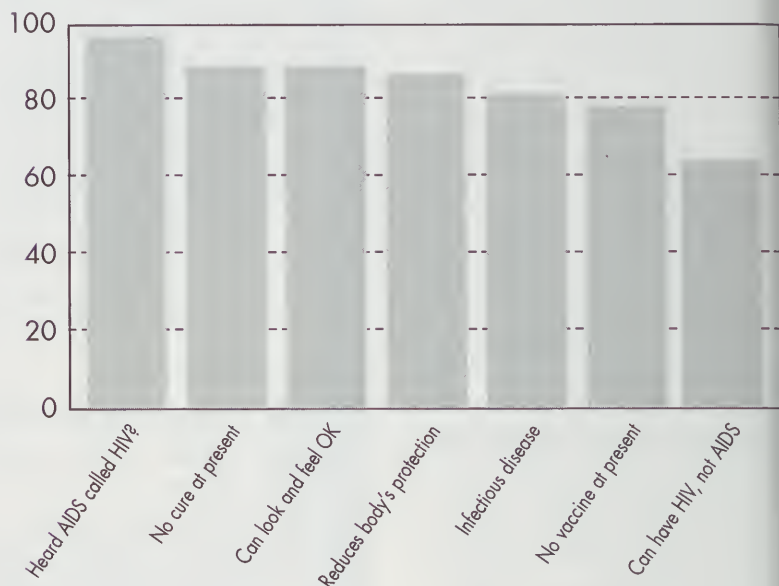
had heard the AIDS virus called HIV, and nearly 90 percent knew that there is no cure for AIDS at the present, that a person with AIDS can look and feel healthy, and that AIDS reduces the body's natural protection against disease (Figure 1A). Understanding that AIDS is an infectious disease and that there is no vaccine available was slightly less common (78 to 81 percent). The fact that someone can have the AIDS virus but not have the disease AIDS was misunderstood by over one-third of subjects.

Most subjects had a good understanding of the ways the disease is likely to be transmitted. Over 90 percent of subjects knew that the AIDS virus can be passed along through sexual intercourse, by sharing needles with an infected person or from a pregnant woman to her baby, while 86 percent knew that the AIDS virus can be transmitted by receiving a blood transfusion from an infected person (Figure 1B).

There were, however, many misconceptions about the ease of transmission of the AIDS virus through casual contact. The most alarming result was the widespread belief, shared by more than two-thirds of subjects, that it was very likely they could acquire the disease from

Figure 1A. Percent of adolescents answering correctly to general AIDS knowledge questions, New Jersey, 1996.

Percent of respondents correct



General AIDS knowledge question

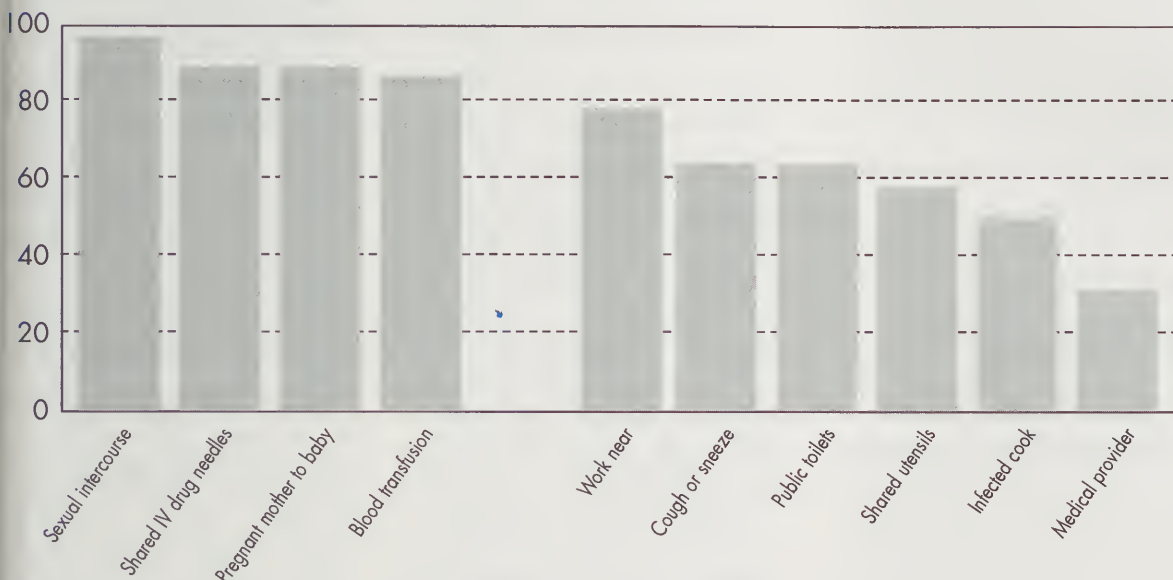
an infected medical provider. Misconceptions about transmission via food prepared by an infected person (over one-half incorrect) also were extremely prevalent. In addition, fewer than two-thirds of the subjects were aware that it is very unlikely or definitely not possible to acquire the disease by using public toilets, sharing plates, cups, or other utensils with an infected person, or coughing or sneezing. The only type of casual contact that was well understood not to pose a

risk was working near someone with the virus (84 percent correct). Subjects answered on average only about seven of the ten transmission questions correctly.

Results. *Sociodemographic differences in AIDS knowledge.* A summary measure based on the percentage of all questions was used to compare knowledge levels across groups. A student was considered to have "passed" the AIDS knowledge test if the student answered at least three-quarters of the AIDS

Figure 1B. Percent of adolescents answering correctly to AIDS transmission questions, New Jersey, 1996.

Percent of respondents correct



AIDS transmission question

questions correctly. Overall, approximately 61 percent of the students attained a passing score; however, there were significant differences according to several sociodemographic characteristics. Figure 2 shows the odds-ratios and associated 95 percent confidence intervals of a passing score by each of the demographic subgroups, adjusted for all of the other demographic factors. An odds ratio below 1.0 indicates a lower chance of passing the

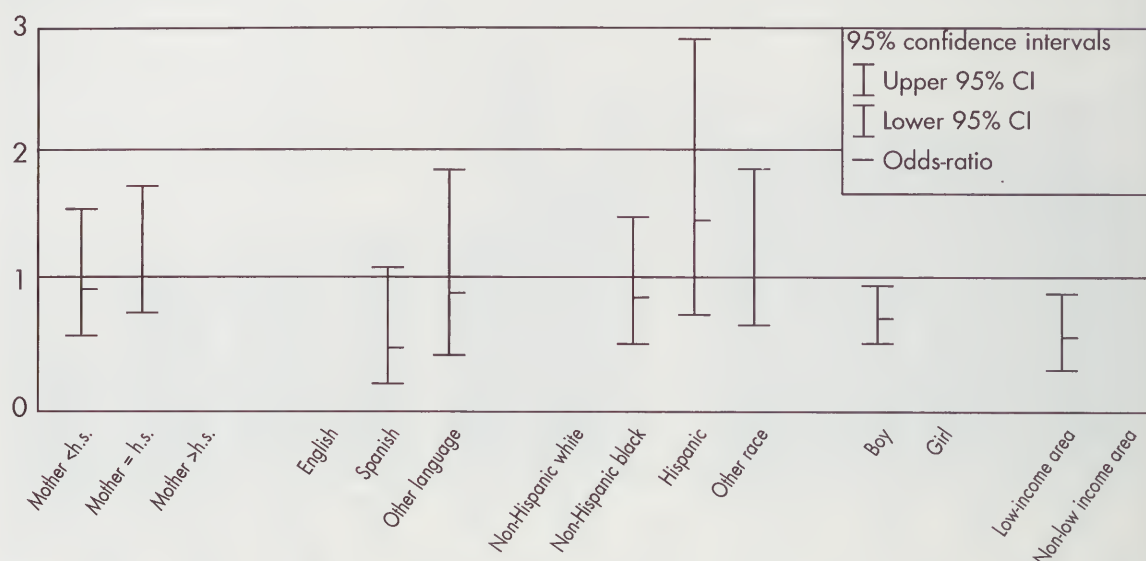
test, compared to the omitted category. If the confidence interval associated with a particular group includes 1.0, the difference between it and the omitted group is not statistically significant at $P < .05$. Preliminary analyses demonstrated that neither the school the respondent attended nor whether the school was Catholic were associated with chances of a passing score once the individual-level characteristics of the respondents

and their area of residence were controlled, so those two variables were dropped from the model.

Based on the multivariate logistic model, only gender, residence in a low-income area, and language spoken at home were significantly associated with the odds of attaining a passing score. Boys were only about 65 percent as likely as girls, and persons from low-income areas just over one-half

Figure 2. Odds-ratios (and 95 percent CI) of a passing AIDS knowledge score by sociodemographic characteristics, New Jersey adolescents, 1996.

Odds-ratio of passing



Sociodemographic characteristic

Adjusted for all characteristics shown in the chart.

Passing score: At least 75 percent of questions answered correctly.

as likely as those from higher income areas, to pass the test. Students who spoke Spanish at home were about one-half as likely to pass as those who spoke English ($P=.06$); this difference cannot be attributed to problems reading or understanding English, because these students completed the questionnaire in Spanish. Although students who reported that they had discussed AIDS with a parent in the past year had slightly higher knowledge

levels than those who did not, this difference was not statistically significant when other attributes were taken into account. Having learned about AIDS in school was not significantly associated with knowledge scores in this sample. Characteristics that were associated with lower odds of a passing score also were associated with relatively poor performance on each of the AIDS knowledge questions (not shown).

Results. Sources of AIDS information. More than 90 percent of subjects reported having seen a public service announcement (PSA) about AIDS on television in the past year, while about 66 percent had heard such a PSA on the radio (Table 2). Just over three-quarters of the subjects reported having received AIDS instruction in school, but only 54 percent had discussed AIDS with their parents.

The open-ended question elicited a wide range of sources of information about AIDS. The teens in our study listed formal sources such as television, newspapers, and school health classes captured in previous surveys, but they also mentioned a variety of informal sources such as people with AIDS, peers or siblings, music, and the Internet, which have not been inquired about in most other studies. The most commonly reported sources of AIDS information were newspapers or magazines (mentioned by 34 percent of respondents) and friends (32 percent). Other popular sources were varied school sources (27 percent, including science courses, DARE instruction, teachers, and coaches), books, and television (approximately 22 percent each).

Discussion and conclusions. Our survey of AIDS knowledge among middle and high school students in New Jersey in 1996 showed a high level of awareness of most attributes of the disease, although there were some significant misconceptions.

One encouraging finding is that most teens were aware of the major modes of AIDS transmission and knew that neither a cure nor a vaccine to prevent

the disease is available at present. These findings are consistent with knowledge patterns among adults in New Jersey,⁹ and nationwide,^{10,12} and show that people have a good understanding of the most critical facts about the disease and its transmission.

Several studies have shown that although higher knowledge levels tend to be associated with higher rates of change to safe behaviors, knowing the facts does not necessarily translate into safer behavior.^{11,13-15}

Consistent with previous studies, we also found that misconceptions about being infected with the virus without having the disease and about transmission through casual contact were quite prevalent.⁹⁻¹⁰ A particularly worrisome finding is the false belief, held by two-thirds of the teens in our study, that it is likely that someone could contract AIDS from an infected medical provider. Because subjects were more likely to hold this misconception if they reported having received information from the print or electronic media, this belief may have been influenced by the considerable media attention about one dentist who transmitted the virus to several of his patients. This evidence of the power of the

media to spread information about the disease underscores the importance of putting such events in context by describing how frequently they do or do not occur, rather than simply reporting on isolated incidents.

Health education programs also must convey that people who are infected can feel healthy and may not exhibit symptoms of the disease, so that those at risk do not wait until symptoms appear before they get tested or change their behavior to reduce the chances of spreading the virus. When educating adolescents, particular attention must be paid to the fact that persons in this age group often do not grasp the long-term repercussions of their current actions, and may feel that a chronic disease is irrelevant to them. It also is important to correct misconceptions about transmission of the virus via casual contact in order to reduce discrimination against infected persons in schools, the workplace, and other community settings. Fear about interacting with persons with AIDS is lower among persons without these beliefs.¹⁶

We found significant deficits in AIDS knowledge among boys, residents of low-income areas, and Spanish-speaking persons. Each of these groups

was only about one-half to two-thirds as likely as their peers to be able to answer at least three-quarters of the AIDS questions correctly. Other studies, too, have found lower knowledge levels among boys.^{10,17} Because knowledge levels were no lower among Hispanics whose primary language was English than among other English-speaking persons, an important consideration when studying risk factors or developing interventions is to differentiate between ethnicity and language spoken. Because each of the three groups identified as having lower AIDS knowledge levels also are at higher than average risk of acquiring AIDS, these findings underscore the need to target these groups.

Another important finding concerns the wide array of sources of AIDS information reported by our study subjects. These sources include the more formal or official means that public health educators use to convey information to adolescents, such as PSAs, school-based health education programs, books, and medical caregivers, but also a varied list of less formal sources, such as peers, the Internet, and music. This finding is significant for several reasons. First, given the widespread misunderstand-

ings among adults and adolescents in the general population about some important characteristics of the disease and how it is transmitted, informal sources such as peers or people with AIDS should not be relied upon to provide accurate information about HIV and AIDS. Second, in the adolescent age group, both rebellion against adults and other authority figures, and identification with peers may cause adolescents to grant greater credence to the less formal and potentially less accurate informants.¹⁸ However, there is some evidence that teens are willing to accept AIDS information from adult authorities, particularly teachers, counselors, and medical providers. In our sample, over one-quarter of subjects reported receiving information in school (other than in formal health education class), but only 13 percent of girls and 6 percent of boys reported having received information from a medical provider. Health care workers who are involved with adolescents should bear in mind their potential contribution to AIDS education, particularly in the one-on-one setting where private concerns and questions can be dealt with sensitively.

Finally, it is important to note that our sample is not representative of all adolescents in New Jersey because the survey included only in-school students in two moderate to high-risk counties. Because teens who are not in school have not had recent exposure to the school-based health education programs and may be more likely to have learned about AIDS from informal sources such as peers or people with AIDS, their understanding of the disease and its causes may be even poorer than that of the students studied here. Because out-of-school adolescents are more likely than their in-school peers to be sexually active, to have multiple sexual partners, and to use illicit drugs, they are also at higher risk of becoming infected with the disease.¹⁹ For both of these reasons, school dropouts represent a critical target group for the design of interventions to increase knowledge and promote safe health behaviors to prevent the spread of AIDS.

References

1. Centers for Disease Control: AIDS cases by age group, exposure category, and sex, reported July 1994 through June 1995, July 1995 through June 1996; and cumulative totals, by age group and

exposure category, through the 1996, United States. 1996. [Available online: <http://www.cdcnac.org:72/00/midyear96/table3.txt>]

2. Singh GK, Kochanek KD, MacDorman MF: Advance report of final mortality statistics, 1994. Monthly vital statistics report 1996;45 (3, supplement). Hyattsville, Maryland, National Center for Health Statistics.

3. U.S. Department of Health and Human Services: National AIDS hotline training bulletin #114. Jan. 6, 1995. Available at: <ftp://hwbbbs.jbgm-umc.org/library/youth/teens94.txt>

4. Coyle SL, Boruch RF, Turner CF: Evaluating AIDS Prevention Programs. Washington, DC, National Academy Press, 1989.

5. Centers for Disease Control: AIDS cases in adolescents and adults under age 25, by sex and exposure category. 1996. [Available online: <http://www.cdcnac.org:72/00/4/midyear96/table7.txt>]

6. Kann L, Warren CW, Harris WA, et al.: Youth risk behavior surveillance—United States, 1993. *MMWR* 44(SS-1):1, 1995.

7. Centers for Disease Control and Prevention: HIV/AIDS Surveillance Report, 1995. Volume 7. Atlanta, GA,

Centers for Disease Control and Prevention, 1996.

8. Benson V, Marano MA: Current estimates from the National Health Interview Survey. National Center for Health Statistics, Vital and Health Stats 10:160, 1994.

9. Miller JE: AIDS knowledge among New Jersey adults. *NJ Med* 93:49, 1996.

10. Schoenborn CA, Marsh SL, Hardy AM: AIDS knowledge and attitudes for 1992: Data from the National Health Interview Survey. Advance Data, Number 243. Hyattsville, Maryland, Centers for Disease Control and Prevention, National Center for Health Statistics, 1994.

11. Anderson JE, Kann L, Holtzman D, et al.: HIV/AIDS knowledge and sexual behavior among high school students. *Fam Plan Perspec* 22:252, 1990.

12. DuRant RH, Ashworth CS, Newman C. et al.: High school students' knowledge of HIV/AIDS and perceived risk of currently having AIDS. *J Sch Health* 62:59, 1992.

13. Ku LC, Sonenstein FL, Pleck JH: The association of AIDS education and sex education with sexual behavior and condom use among teenage men. *Fam Plan Perspec* 24:100, 1992.

14. Goodman E, Cohall AT: Acquired immunodeficiency syndrome and adolescents: Knowledge, attitudes, beliefs, and behaviors in a New York City adolescent minority population. *Peds* 84:36, 1989.

15. Holzman D, Lowry R, Kann L, et al.: Changes in HIV-related information sources, instruction, knowledge, and behaviors among U.S. high school students, 1989 and 1990. *AJPH* 84:388, 1994.

16. Skurnick JH, Johnson RL, Quinones MA, et al.: New Jersey high school students' knowledge, attitudes, and behavior regarding AIDS. *AIDS Ed Prev* 3:21, 1991.

17. Dusenbury L, Botvin GJ, Baker E, et al.: AIDS risk knowledge, attitudes, and behavioral intentions among multi-ethnic adolescents. *AIDS Ed Prev* 3:367, 1991.

18. Blair JF, Hein KK: Public policy implications of HIV/AIDS in adolescents. *The Future of Children: Critical Health Issues for Children and Youth* 4:73, 1994.

19. Centers for Disease Control and Prevention: Health risk behaviors among adolescents who do and do not attend school—United States, 1992. *MMWR* 43:129, 1994.

LET'S TALK!
NEED A BUSINESS LOAN?
CALL US FOR...
EXPERT HELP
FABULOUS SERVICE
COMPETITIVE RATES
FAST APPROVALS AND CLOSINGS

Loans up to approx. \$1,500,000 under the U.S. Small Business Administration Guaranteed Loan Program.
 Approvals in 24 hours, or less.

Preferred (PLP) lender in New Jersey, New York and Pennsylvania.



Call 1-800-SBA-2005
 ask for the "SBA Specialist"

PRESTIGE STATE BANK



Equal Housing Lender Equal Opportunity Lender

Member FDIC

MAC



Are you a Hospital or Physician who wants

PHYSICIAN ASSISTANT LET **PA CONSULTANTS, INC.** **DO THE WORK**

Through our:

CONSULTATION PROGRAMS

Comprehensive review of state laws with an overview
 the physician assistant profession

EDUCATIONAL PROGRAMS

Our inservice programs will educate all employees who
 come in contact with the new and exciting field

PLACEMENT

Our placement program will guarantee finding a qualified
 licensed candidate from our nationwide database

PA CONSULTANTS, INC.
 3857 HIGHWAY 9
 SUITE 105
 FREEHOLD, NJ 07728

PHONE: 732-683-1000
FAX: 732-683-1000



Druker, Rahl & Fein

Business Consultants
 Certified Public Accountants

We have your prescription to profitability

We're Druker, Rahl and Fein, the accountants and advisors
 to physicians and health care providers.

...Managed Care..Government Regulations

..the industry is changing..quickly.

How will these changes affect your practice?

You have questions and you need answers.

Our medical services experts will assist you

in developing a strategy to

succeed in this dynamic environment.

Leaders in:

Cost Accounting • Strategic Planning • Group Practice Formation • Tax
 Managed Care Analysis • Practice Valuations • Practice Management

200 Canal Pointe Boulevard • Princeton, NJ 08540-5998 • 609-243-9700 • FAX 609-243-9799

Contact Robert J. Rahl, CPA

CHANGING THE OUTLOOK OF GASTROENTEROLOGY

M. Arif Hashmi, MD

Dr. Hashmi, board certified in gastroenterology, is affiliated with West Jersey Health System, Our Lady of Lourdes Medical Center, and Cooper Health Medical Center. Dr. Hashmi also is a member of the MSNJ Council on Communications.

During the past ten years, changes in the understanding and management of gastrointestinal diseases have been remarkable. A clinical report on these modifications and improvements will lead to a clearer discernment of such disease patterns.

***Helicobacter pylori* (HP).**

HP is one of the most common infections worldwide. Sixty percent of the world's population is colonized by this organism; most are asymptomatic. A definite route of infection has not been defined but most likely its spread is via the fecal-oral route. HP infection seems to be acquired from contaminated water, and iatrogenic spread by contaminated endoscopes can occur.

HP infects only the gastric mucosa and is unique in its ability to produce an alkaline microenvironment by hydrolyzing urea to ammonia and carbon dioxide with urease. The organism is not invasive but produces several enzymes and toxins.

All HP infections cause a chronic active gastritis and almost 100 percent of duodenal ulcers and 80 to 90 percent of gastric ulcers not due to NSAIDS are related to this infection. Eradication of HP reduces the ulcer recurrence rates from 60 to 80 percent a year to less than 5 percent. HP infection is an important risk factor for the development of gastric adenocarcinoma of the intestinal type. Low-grade mucosa and lymphoid tissue lymphomas (MALTomas) also are associated with HP infection as eradication of the infection induces remission in most cases.

Currently, evaluation of endoscopically obtained gastric tissue is the primary mode of diagnosing HP infection. This

is accomplished by urease testing or histology while culture primarily is a research tool. Urea breath tests probably will replace endoscopy as the preferred method of diagnosing active HP infection. Since antibody levels decline slowly over several years or not at all after eradication of HP, positive serology does not predict active infection. Therefore, treatment decisions should not be based on serology alone.

The gold standard for treatment of HP is a two-week course of tetracycline, metronidazole and bismuth subsalicylate. However, this treatment is poorly tolerated and combinations of proton-pump inhibitors—amoxicillin and macrolid—are becoming the favored regimen.

The most important issues for the future are the development of a vaccine and overcoming the emerging antibiotic resistance.

Viral hepatitis. The viral hepatitis alphabet continues to grow. Researchers are exploring the importance of hepatitis

G virus in liver diseases. Hepatitis C virus (HCV) continues to be the most important causative agent of infectious liver disease in this country. HCV is transmitted primarily by the percutaneous route, and testing of HCV antibodies and surrogate markers in donated blood has reduced the risk of post-transfusion hepatitis to 1 per 100,000 units transfused. The most common sources of infection are intravenous drug abuse, needle-stick accidents, hemodialysis, and intranasal cocaine use. Sexual transmission is rare and maternal-fetal transmission during delivery occurs in 6 percent of babies born to infected mothers.

The median incubation period of HCV infection is seven weeks. Most infections are asymptomatic and only 25 percent become icteric. Between 80 and 90 percent of patients develop chronic infection, which typically causes waxing and waning aminotransferases. Chronic hepatitis C is an indolent infection and will cause cirrhosis in 20 percent of patients in 20 years. It is the second most important risk factor for the development of hepatocellular carcinoma and 1 to 5 percent of patients will

develop this tumor after 20 years.

The diagnosis of HCV is made by detection of anti-HCV antibodies that appear nine to ten weeks postexposure. These antibodies do not necessarily denote active infection; this is confirmed by detecting HCV RNA in the serum.

The standard treatment of chronic HCV infection consists of administering three million units of alpha interferon subcutaneously for 12 months and treatment currently is recommended for all infected patients except those with normal aminotransferases, decompensated cirrhosis, autoimmune disease, post-transplantation, and for patients abusing alcohol or drugs.

Progress in development of a vaccine has been slow and attention is focused in developing more effective interferons; treatment with a combination of interferon and ribavirin holds the most promise.

Antibiotic prophylaxis.

Dilatation of esophageal strictures, sclerotherapy of esophageal varices, and endoscopic retrograde cholangiography of an obstructed bile duct where adequate drainage is not

established, are felt to cause transient bacteremia with significant frequency; SBE prophylaxis is recommended in high-risk cardiac conditions and is optional in moderate risk conditions. There continues to be confusion regarding appropriate antibiotic prophylaxis for gastrointestinal procedures. The American Heart Association recently published recommendations and categorized prosthetic cardiac valves, previous history of endocarditis, complex cyanotic congenital heart disease, and surgically constructed systemic pulmonary shunts as conferring high risk for development of subacute bacterial endocarditis (SBE). Other congenital cardiac malformations, acquired valvular disease, hypertrophic cardiomyopathy, and mitral valve prolapse with regurgitation were assigned a moderate risk.

The recommended SBE prophylaxis consists of amoxicillin 2 gm taken orally two hours before esophageal procedures. Cephalosporins, clindamycin, or a macrolid may be substituted in penicillin-allergic patients. For other gastrointestinal procedures, ampicillin 2 gm and gentamycin 1.5 mg/kg body

eight should be given intravenously within 30 minutes of the procedure and a second dose of ampicillin parenterally or amoxicillin 1 gm orally should be given six hours later. Vancomycin is the substitute for penicillin-allergic patients and a second dose is not necessary.

Genetics of colon cancer. Colorectal cancer (CRC) is felt to develop through an adenoma-to-carcinoma sequence, due to a cascade of genetic events where oncogene mutation and the loss of tumor suppressor and DNA repair genes lead to uncontrolled cell proliferation and formation of a neoplasm.

Oncogenes are mutated forms of normal genes. Oncogenes associated with CRC are the Ras genes and K-ras mutations, which are present in 50 percent of CRC and adenomas larger than 1 cm.

Tumor suppressor genes suppress cell proliferation and, therefore, tumor formation. The adenomatous polyposis coli (APC) gene is abnormal in familial adenomatous polyposis coli, which is an autosomal dominant condition in which hundreds of colorectal adenomas develop in childhood; the development of CRC is in-

evitable. The APC gene also is abnormal in 60 percent of sporadic CRC. The p53 gene arrests the cell cycle when DNA damage occurs, allowing time for repair and, thereby, preventing tumorigenesis. Hereditary nonpolyposis colon cancer (HNPCC) syndrome is an autosomal dominant disease that predisposes affected patients and their kindred to CRC and other cancers. This syndrome is felt to be due to inactivation of mutation repair genes (hMSH2, hMLH1, hPMS1, and hPMS2), which help to repair abnormalities in newly formed DNA.

Nonalcoholic steatohepatitis. Fatty infiltration of the liver can occur in the absence of chronic alcohol use. Nonalcoholic steatohepatitis (NASH) is a term given to this type of fatty infiltration when accompanied by elevations of the aminotransferases. The prevalence of this disorder is 1.2 to 9 percent, and it is most often associated with obesity, poorly controlled diabetes mellitus, hyperlipidemia, and rapid weight loss. Abnormalities in free fatty acid metabolism are felt to be responsible for the accumulation of triglycerides in the liver. NASH is seen most frequently in the fifth and sixth

decades of life and it has a female preponderance. Most patients are asymptomatic and its clinical course is usually indolent and benign. However, 40 percent of cases can progress to fibrosis and 15 percent can progress to cirrhosis. A liver biopsy is diagnostic and shows steatosis along with portal or lobular inflammation. No specific therapy is available. Weight reduction and control of blood sugars and hyperlipidemia should be advised.

Celiac disease. Celiac disease or gluten sensitive enteropathy is a malabsorptive disorder. The hallmark of this disorder is villous atrophy and signs of mucosal immune activation, with reversal of these changes on a gluten-free diet. An association with HLA class II antigens has been identified. Celiac disease is felt to be an under-diagnosed disorder since it can present as malabsorption of a single dietary component such as iron, and the histologic abnormalities may be patchy or incomplete.

The ability to assay anti-gliadin, antiendomysial, and antireticulin antibodies allows physicians to diagnose subtler forms of celiac disease since the IgA antibody against

smooth muscle endomysium has a sensitivity of 74 percent and a specificity of 100 percent. The antiigliadin antibodies are much less sensitive and specific false negatives can occur in IgA deficiency.

Endoscopy. During the last decade, gastrointestinal endoscopy has progressed from a purely diagnostic tool to an important therapeutic modality and an alternative to surgery.

Bleeding lesions in the gastrointestinal tract now can be both accurately diagnosed and treated endoscopically with the use of cautery devices, injections, lasers, and ligation with rubber bands. Plastic and expanding metal stents allow endoscopists to relieve obstructions in the esophagus, duodenum, colon, pancreas, and bile ducts. Tumor ablation for prevention of bleeding or obstruction is possible with lasers and electrothermal devices. Endoscopic biliary sphincterotomy has become an accepted method of treating choledocholithiasis and bile duct stones can be extracted and also fragmented with mechanical, electrohydraulic, or laser lithotriptors. Endoscopic ultrasound is being used for diagnostic imaging and guided

biopsy and also for staging tumors since it can delineate the individual layers of the bowel wall.

References

1. Cave DR: Epidemiology and transmission of *Helicobacter pylori* infection. *Gastroenterology* 113:S9-S14, 1997.

2. Graham DY, Alpert LC, et al.: Iatrogenic *Campylobacter pylori* infection is a cause of epidemic achlorhydria. *Am J Gastroenterol* 83:974-980, 1995.

3. Kelly SM, Pitcher MC, et al.: Isolation of *Helicobacter pylori* from feces of patients with dyspepsia in the United Kingdom. *Gastroenterology* 107:1671-1674, 1994.

4. Correa P: *Helicobacter pylori* and gastric carcinogenesis. *Am J Surg Pathol* 19 (Suppl 1):S37-S43, 1995.

5. Sackmann M, Morgner A, et al.: Regression of MALT lymphoma following eradication of *Helicobacter pylori*. *Gastroenterology* 113:1087-1090, 1997.

6. NIH Consensus Development Conference Panel State-

ment: Management of hepatitis C. *Hepatology* 26 (Suppl 1):2S-10S, 1997.

7. Conry-Cantilene C, Vanraden M, et al.: Routes of infection, viremia, and liver disease in blood donors found to have hepatitis C infection. *N Engl J Med* 334:1691-1696, 1996.

8. Dajani AS, Taubert KA, et al.: Prevention of bacterial endocarditis. *JAMA* 277:1794-1801, 1997.

9. Corethers JM: The cellular and molecular pathogenesis of colorectal cancer. *Gastroenterol Clin N Am* 25:737-754, 1996.

10. Sheth S, Gordon F, Chopra S: Nonalcoholic steatohepatitis. *Ann Int Med* 126:137-145, 1997.

11. Annese V, Basciani M, et al.: Controlled trial of botulinum toxin injection versus placebo and pneumatic dilatation in achalasia. *Gastroenterology* 111:1418-1424, 1996.

12. Valdimarson T, Franzen L, et al.: Is small bowel biopsy necessary in adults with suspected celiac disease?

Dig Dis Sci 41:83-87, 1996.

ADVANCES

Robin K. Levinson

Aging baby boomers, computerized surgical tools, outpatient procedures, and intense media interest have helped spark an explosion in cosmetic surgery in New Jersey over the last few years.

The annual number of cosmetic procedures performed by plastic surgeons in the United States has soared from 408,000 in 1994, to approximately 717,800 cases in 1996, according to the American Society of Plastic and Reconstructive Surgeons (ASPRS). Thousands more were performed by physicians who are not ASPRS members.

"In years past, aesthetic surgery was considered an elitist procedure reserved for the wealthy," says Allen D. Rosen, MD, a Bloomfield-based plastic surgeon and member of the Medical Society of New Jersey (MSNJ). "Over this decade, however, the public has been realizing that it also is available to those who want an aspect of their physical form

improved to help themselves feel better.

"We can offer these procedures at lower prices in local surgicenters and in office operating rooms, using shorter-acting anesthetics that let patients recover more quickly," continues Rosen, an assistant clinical professor at the University of Medicine and Dentistry of New Jersey (UMDNJ). "Also, improvements in technology and techniques make us able to achieve better results with less morbidity than we saw a decade ago."

The latest, most dramatic technological improvement is the CO₂ ultrapulsed laser—a high-tech wrinkle-reducing alternative to the chemical peel and dermabrader. More than 46,200 "laser peels" were reported in 1996 compared with none in 1994, according to ASPRS.

The ultrapulsed laser vaporizes the top few skin layers, taking with it many facial wrinkles and pigment irregularities caused by decades of sun exposure and natural skin

aging. New skin that grows up generally is smoother and more uniform, often shaving years off the patient's appearance.

"The ultrapulsed laser has become the standard for wrinkle control and facial acne scarring," says Arthur W. Perry, MD, a Franklin Park-based plastic surgeon with faculty appointments at UMDNJ-Robert Wood Johnson Medical School and the University of Pennsylvania School of Medicine.

"As long as the surgeon is properly trained, it works well. Sometimes, the laser peel must be accompanied by a canthopexy to tighten the lower eyelids if they are too lax," Perry notes. Otherwise, the peel may create a pull-down of the eyelids.

A new twist on the number one cosmetic procedure, liposuction, is ultrasound-assisted liposuction (UAL). UAL is similar to traditional tumescent liposuction in that it suctions out pockets of unwanted fat through a thin cannula inserted under the skin. In UAL, the cannula first delivers high-frequency ultra-

COSMETIC SURGERY HITS MAINSTREAM NEW JERSEY



Pre- and post- profiles of a laser peel.

PHOTOGRAPHS COURTESY OF THE AMERICAN SOCIETY OF
PLASTIC AND RECONSTRUCTIVE SURGEONS

sonic vibrations, which burst open surrounding fat cells. The fractionated fat then is suctioned out of the body. According to the ASPRS, UAL results in "less bleeding, bruising, and discomfort leading to shorter periods of convalescence" compared with traditional liposuction.

While UAL may be appropriate for the male breast, the flanks, the posterior back, and central body regions, Rosen points out UAL often must be combined with traditional liposuction to achieve the desired effect. Traditional liposuction

still is considered superior to UAL for removing unwanted fat from the face, neck, knees, and inner thighs.

Another recent trend in cosmetic surgery—endoscopy—also has its limitations. Some plastic surgeons have begun using endoscopes for breast augmentation, face-lifts, forehead-lifts, and tummy tucks. Studies suggest, however, that the forehead-lift may be the only aesthetic procedure in which endoscopy is superior to conventional techniques.

"Traditionally, the forehead-lift required an incision from

ear to ear across the hair-bearing scalp, which left some numbness," Rosen says. "Now we operate through small slits in the hair-bearing scalp, doing work on muscles and releasing some tissue. Endoscopy gives us a way to achieve the same result with less potential for certain complications."

For a 66-year-old consultant from Essex County, cosmetic surgery has been a rejuvenator. Since 1993, she has spent a total of \$45,000 on a tummy tuck, laser peel, eyelid-lift, and a face-lift.

"I am getting older, and I just decided that I wanted to keep my face and body looking as good as possible," says Marion, who asked that her real name not be used. "I feel that I do look younger. I deal with a lot of younger women in my work, and a number of them have said, 'What in the world do you use on your skin?' "

While studies show that the majority of cosmetic surgery patients are satisfied, bad outcomes do occur. Sandra (not her real name), a 58-year-old former New Jersey resident, is bitterly disappointed with the results of her laser peel, which she had in the summer of 1996.

"I ended up with all kinds of streaking and other problems," says Sandra. "I just spent over \$1,000 trying to get that corrected by a dermatologist. He took away the streaking, but my peel had taken all the pigment out of the skin on my cheeks. I used to have pretty, olive skin. Now my cheeks are white. And around my mouth, my skin is what it used to look like. I'm scarred for life."

Despite being educated through the media, patients still need a realistic, individualized assessment from their surgeons, says Englewood-based Richard A. D'Amico, MD, president-elect of the New Jersey Society of Plastic Surgery and an



Pre- and post- traditional liposuction patient showing stomach and thighs.

PHOTOGRAPHS COURTESY OF THE AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS

ASPRS board member. "We need to remind them that even though we're not necessarily cutting through the skin, it's still surgery and there still can be complications."

Unfortunately, often the public seems to give more credence to the media than to science, according to Perry, a member of the MSNJ Council on Communications.

"Cosmetic surgery is the only field in medicine where physicians change their surgical procedures based on what's on TV this week," Perry says. "In cardiology, changing from one drug to another requires a ran-

domized, controlled, double-blind study in a respected peer-reviewed journal, plus corroboration. But in plastic surgery, when you see, for example, ultrasonic liposuction on the national news, all of a sudden everyone jumps on the bandwagon. Even in cases where traditional liposuction has a clear-cut advantage, people are demanding UAL.

"A couple of days after any cosmetic story appears on TV, my office is flooded with calls," Perry continues. "Nothing else in medicine is so patient-driven."

NJM

ONE WORLD ONE COMPANY ONE PURPOSE

Helping All People Live Healthy Lives



Becton Dickinson begins its second century committed to a corporate vision: to become the organization most known for eliminating unnecessary suffering and death from disease.

This is an ambitious goal... one we are proud to share with hundreds of humanitarian relief, health care, educational, cultural and social service organizations around the globe.

**BECTON
DICKINSON**

DES-EXPOSED MOTHERS, DAUGHTERS, AND SONS

It was known as the miracle drug. Diethylstilbestrol (DES), a synthetic form of estrogen, was given to millions of pregnant women from 1938 until November 1971 to prevent miscarriages. Unfortunately, DES was ineffective, and worse, it was linked to reproductive problems in the daughters of DES-exposed mothers.

In 1971, after DES was linked to a rare vaginal cancer in DES daughters, the Food and Drug Administration told physicians to stop prescribing it.

Until that time, DES was promoted heavily by advertising from major drug companies. Almost five million pregnant women and their unborn fetuses were exposed to DES.

In New Jersey alone, it is estimated that there are 305,000 DES-exposed people: 152,500 mothers, 76,250 daughters, and 76,350 sons. It still is unknown whether DES

exposure will affect future generations.

It is known that DES-exposed daughters are at greater risk for ectopic pregnancy and premature labor; the increased risk to a rare cancer and other problems are less well known. Also, as DES-exposed daughters approach menopause, the medical community will need to address new concerns. The risks to DES mothers and sons also have been neglected. According to Dr. Sherry Mills, Project Director of The National DES Education Project (a research and provider education program mandated by Congress), "With better information about DES, physicians can improve the early detection, diagnosis, and treatment of medical conditions associated with DES exposure in this high-risk population."

Risks to daughters. Of the many risks to DES daughters, perhaps the most feared is clear cell adenocarcinoma. This invasive cancer of the vagina or cervix usually occurs after age 14, with the highest risk for those from ages 15 to 22. Although the number of cases declines thereafter, clear cell cancer continues to be a risk; it has been found in DES daughters in their 30s and 40s. Older

DES daughters should not be considered risk-free; clear cell adenocarcinoma in women not exposed to DES usually occurs after menopause.

In addition, there is some concern that DES daughters may have an increased risk of breast cancer as well as an increased risk of developing squamous cell carcinoma. There also is evidence that DES-exposed women are at greater risk for developing intraepithelial neoplasia of the cervix and vagina.

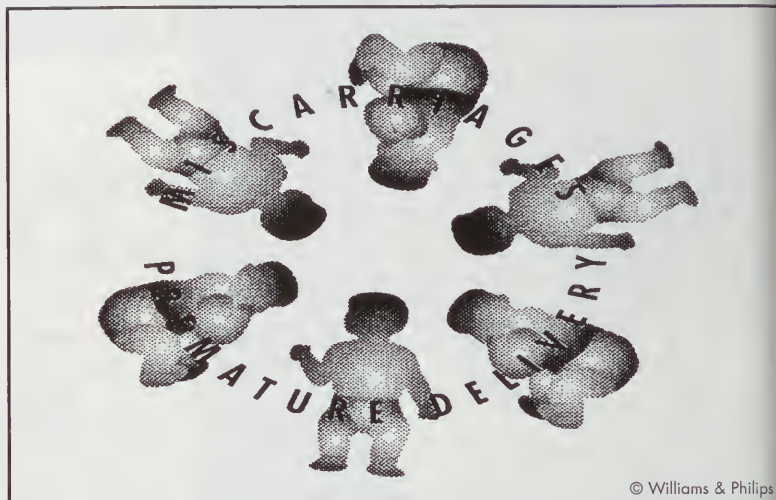
Higher rates of menstrual irregularities have been reported in DES daughters. Other health risks have been investigated, demonstrating a slightly increased risk of various autoimmune disorders and eating disorders, such as profound weight loss.

"The major problem I see in DES-exposed patients is infertility due to uterine abnormalities," notes ob/gyn and reproductive endocrinologist, Althea O'Shaughnessy, MD, medical director, The Princeton Center for Infertility and Reproductive Medicine and Medical Society of New Jersey member. More than one-third of DES daughters have gross structural changes in their vaginas, cervices, and/or uteri. These malforma-

tions typically include cervical "collars" or "hoods," and "T-shaped" uteri.

Other reproductive problems, including miscarriages and premature delivery, are prevalent among DES daughters. Because of increased structural abnormalities and possible cervical incompetence, the use of prophylactic cerclage once was encouraged for all DES daughters. However, conservatively managed patients still may have good pregnancy outcomes and routine cerclage no longer is recommended. "Nevertheless, patients should be followed closely because the cavity often is narrow and cervical incompetence can be a problem," advises O'Shaughnessy.

Perinatologist, clinical geneticist, and medical director of Maternal-Fetal Medicine at Mercer Medical Center, Patrice Trauffer, MD, sees the effects of DES exposure through her patients' "infertility problems, recurrent miscarriages, and cervical malformations." As an outreach speaker at several New Jersey hospitals and as assistant professor of ob/gyn at Jefferson Hospital, Trauffer assures physicians and the public that "most DES-exposed women can lead full, reproductive lives, if they are under appropriate and close medical supervision."



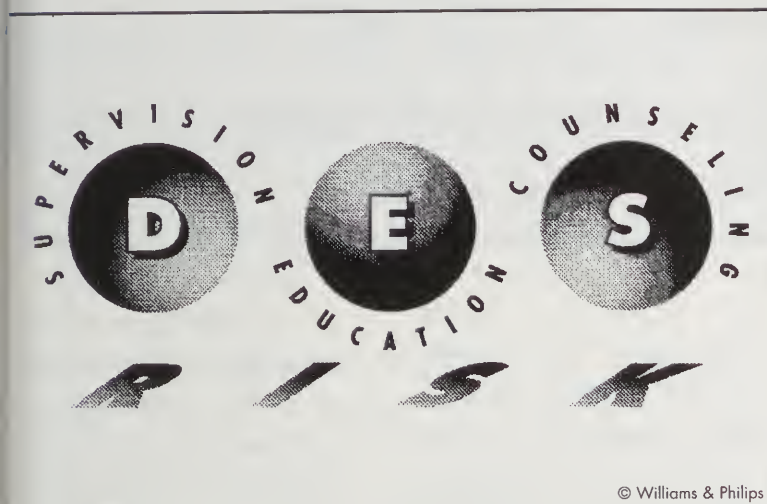
© Williams & Philips

Risks to mothers. Research on women who took DES shows an increased risk for breast cancer. While the amount of risk still is debated, one study of women who took DES over 20 years ago found that DES mothers have a 30 to 35 percent greater risk of developing breast cancer. Studies now are underway on the increased risk in DES mothers for other hormone-related cancers.

Risks to sons. While men exposed in utero to DES seem to exhibit no unusual health problems, DES is known to cause problems with the male genital organs that may require special medical attention. DES sons are more prone to epididymal cysts, undescended testicles, micropallus, testicular varicoceles, hypospadias, meatal stenosis, and possible fertility problems. While there is no conclusive statistical evi-

dence proving an increase in cancer, Michael Freilick, founder of DES Sons Network, states, "The DES-exposed male population has not been adequately studied. When early DES studies were done, exposed men were younger and the increased number of testicular cancers had not yet shown up." Freilick, a DES son who resides in New Jersey, received national support when he publicly discussed his testicular cancer, and exposed the effects of DES on males.

Current medical treatment. Because of all the misinformation about DES, it is important to have accurate, up-to-date information on DES, which is available from DES Action (1/800-DES-9288); DES Cancer Network (1/800-DES-NET-4); DES Sons Network (609-795-1658); and the National Cancer Institute (1/800-422-6237).



© Williams & Philips

Experts feel that physicians must ask patients if they have knowledge of DES exposure. Doctors not experienced in DES examinations should contact DES Action or refer the patient to a physician familiar with the details of DES evaluation and followup.

While examination of a DES-exposed female is similar to a routine pelvic examination, some modifications are needed. The PAP smear should be taken from the circumference of vagina and not just the cervix. The National Cancer Institute recommends the following order when examining DES-exposed females: Clinical breast examination, vulvar inspection, vaginal and cervical inspection (speculum), cytology (separate specimens from vaginal fornices and cervix), colposcopy (optional), iodine stain of cervix and vagina (optional), vaginal and cervical palpation (digital), tissue biop-

sy of atypical findings, and bimanual vaginal examination, including recto-vaginal examination.

Patients should conduct monthly breast self-examinations and have mammographies, as appropriate. Professional breast examinations should be given annually. DES daughters must continue followup examinations throughout their lives. All pregnancies in DES-exposed daughters should be treated as high-risk, regardless of previous pregnancy outcomes, and physicians should treat infertility, conception problems, and miscarriages early and aggressively.

O'Shaughnessy adds that physicians "cannot overlook the DES patients' higher risk for ectopic pregnancy. As soon as a patient is aware of her pregnancy, early monitoring is essential." For DES patients on

any fertility drug, "Getting hysterosalpingograms, early monitoring, early ultrasounds, and betas are necessary. A typically small, DES-affected uterine cavity cannot handle multiple births."

Serious evaluation also must be given when prescribing any estrogens (including birth control pills, morning-after pills, and hormone replacement therapy) due to the possibility of increased cancer risk from additional estrogen.

It is important to make sure female patients understand how to give themselves monthly breast self-examinations. It also is important to make sure male patients know how to regularly examine their testicles, starting at age 16, and that all males over the age of 40 have regular prostate examinations.

The key to reducing the negative impact of DES exposure is through close medical supervision, counseling, and education. Knowledge of DES exposure can result in great anxiety and fear. "Reassure patients that services exist to help them, that they are not alone, and that outcomes are generally good," reminds Trauffer. A patient's anger, guilt, misinformation, sexual and self-image issues, fear of cancer, and concerns about fertility can be reduced through information and support.

NJM

Medical Society of New Jersey

Long Term Care Insurance Program

Ensuring a Secure Future by Preserving Assets

As medical professionals, you know first hand the devastating effects that extended long term care can have on a person's hard earned assets. The cost of nursing home stays can range from \$3,000-\$5,000 per month. The Medical Society of New Jersey endorses The Travelers and CNA Insurance Companies' policies to help you guard against unforeseen tragedies. Through a special arrangement with The Travelers and CNA Insurance Companies, members, spouses, parents and in-laws are eligible for a premium reduction.

IMPORTANT FEATURES OF THE MSNJ ENDORSED LONG TERM CARE INSURANCE PROGRAM

- ◆ Available Ages 45-84
- ◆ Specialty Plans Available Ages 80-100
- ◆ Benefits up to \$250/day
- ◆ No prior hospitalization required
- ◆ Several waiting periods
- ◆ Alzheimer's, senility covered
- ◆ Lifetime benefits available
- ◆ Guaranteed renewable for life
- ◆ Coverage for custodial, skilled and intermediate care as well as adult day care
- ◆ Available to your spouse, parents and in-laws
- ◆ Waiver of premium benefit
- ◆ Inflation protection available

DISCOUNT FOR MEMBERS OF MSNJ, SPOUSES, PARENTS AND IN-LAWS

For more information, please call

DONALD F. SMITH & ASSOCIATES

A division of THE COPELAND COMPANIES*

Two Tower Center, P.O. Box 1063
East Brunswick, New Jersey 08816-1063

(888) 297-7225

Copeland Associates, Inc.

Medical Society
MSNJ

HOPE ON THE HORIZON FOR STROKE PATIENTS

Diane Haring Cornell

The use of thrombolytic therapy has revolutionized the treatment of stroke for a small group of patients, vastly improving outcomes and shortening hospital stays and rehabilitation time. This powerful new therapy also has led some neurologists to envision a day when a stroke's damaging effects can be halted and reversed.

That, for many, is the best outcome of the new therapy. Even though the results can be miraculous, the new drugs only benefit a small number of stroke patients. It is estimated that between 5 and 10 percent of stroke victims are candidates for the treatment. For the vast majority of stroke victims, there still is little that can be done to stop a stroke's harmful effect: tissue death caused by an interruption of blood to the brain.

There are two main types of stroke, ischemic and hemorrhagic. Ischemic stroke, the most common, is caused by blockage of a vessel in the brain, usually formed by a

build-up of cholesterol-containing fatty deposits known as plaque. Hemorrhagic stroke happens when a blood vessel in the brain ruptures. Nationally, about 83 percent of strokes are ischemic; 17 percent are hemorrhagic.

Thrombolytic therapy, of which tissue plasminogen activator (TPA) or activase is the most commonly used, is only effective in the treatment of ischemic strokes. The drug dissolves clots, re-establishing blood supply to the brain, thereby lessening the damage caused by a lack of nutrients. When deprived of an adequate blood supply, brain cells begin to die within four minutes. The amount of damage an ischemic stroke causes depends on the size of the clot and its location.

Piero Verro, MD, medical director of John F. Kennedy Medical Center's stroke unit, has used the drug to treat 21 patients since it was approved by the U.S. Food and Drug Administration for stroke therapy in June 1996. Its approval came after a five-year study by the National Institute of Neurological Disorders and

Stroke found that TPA helped certain ischemic stroke patients who were given the drug within three hours of symptom onset. The patients were 33 percent more likely to recover from a stroke with little or no disability after three months.

However, despite such promising results, many physicians are afraid of the drug's side effects and are not using the therapy. One reason physicians are reluctant to use TPA is that it has a 1 in 16 chance of causing bleeding in the brain, thus worsening a stroke's effects. In addition, the therapy only is recommended for use in patients within three hours of the onset of a stroke. Physicians must depend completely on others for a time line when symptoms started, which often is difficult, leaving many physicians uneasy about using the drug.

"Unfortunately, this therapy has not made a major impact on the care of stroke patients, yet," acknowledges Verro. "There is definitely a reluctance on the part of physicians because of the risks associated with it." But, he says, as the amount of experience with the drug increases, hopefully, too,

will physicians' comfort levels in using it.

Verro reports he has had slightly better results than those reported by the NIH study, about two-thirds of those to whom he has given the drug have had a significantly better response rate within 24 hours than they had at presentation. He also said his patients have not experienced any of the complications that have caused so much worry.

At UMDNJ-University Hospital, in Newark, the Director of Stroke Services Andrea Hidalgo, MD, has treated 12 patients in the past year with the new therapy and says that the risk associated with the therapy "may be exaggerated in some people's minds. As a physician you do not want to cause harm, and since there is a small chance of neurologic worsening, some physicians shy away from ever using the drug, expecting the worst. However, it is worth trying in appropriate patients, where there may be a significant chance of clinical benefit."

Hidalgo has seen bleeding as a complication after this therapy. For example, with very large strokes the risk of bleeding increases, even without TPA. Thus the patient, family, and physician need to take potential benefits versus very real risks into account before deciding to use the drug.

She credits emergency medical services (EMS) personnel for being instrumental in assessing cases of suspected stroke. "It used to be that all EMS could do in these cases was to give them a little oxygen," she says. "Now we have notification directly from the field so members of the stroke service are waiting in the emergency room upon their arrival. The patient gets a computed tomog-



Piero Verro, MD

raphy scan right away to determine any presence of blood (to determine the type of stroke) and to rule out any other etiology that might be causing the same symptoms as a stroke.

The assistant professor of neurosciences at UMDNJ-New Jersey Medical School also is exploring whether the three-hour time window of opportunity to use thrombolytic therapy can be expanded. Hidalgo is one of several neurologists in the country conducting a double-blind study to determine

whether the time frame for administering TPA can be extended. This study uses essentially the same treatment criteria used for thrombolytic therapy, the exception being that the study is more strict on stroke size because of the increased risk of hemorrhage over time.

Other promising areas of research involve administering thrombolytic drugs intra-arterially, which is more selective and may allow a lower dose of the drug. The latter would use an angiogram to locate the clot and a catheter to come close to the blockage in the brain and inject the drug into it.

Hidalgo says success with the new thrombolytic agent has complemented research in neuro-protective agents, which may make brain cells more tolerant of the lack of blood supply during a stroke.

"Neurologists are very excited about these new developments. We're waiting for the time when we can administer a cocktail of medications to limit the different biochemical events that occur during a stroke, even before breaking up the clot and hopefully salvaging as much brain tissue as possible." She says that right now there are active animal studies combining neuroprotective agents with intravenous TPA that have shown a 50 percent or more

reduction in brain stroke size. The combination may protect brain cells during the time they are not getting a blood supply and reduce inflammation and related events that worsen the effects of a stroke," she says.

Verro attributes his success using TPA to careful patient selection and good clinical management after therapy.

"Having a designated stroke unit for followup care is critical in ensuring good outcomes. The close monitoring after treatment has had a major impact on reducing complications," he says. Smaller studies using TPA therapy have been, at best, neutral and, at worst, they reported that the therapy actually harms patients, Verro comments. "One of the questions asked when the NIH study came out was why this study had different results than earlier ones, and one of the issues they found that made a big difference was followup care."

In particular, he notes, is the need to pay attention to the fluctuations in a patient's blood pressure. It has been shown that if blood pressure goes out of control after treatment, patients may suffer hemorrhagic complications at a greater rate. At the stroke unit at John F. Kennedy Medical Center, nurses monitor vital signs and perform neurological checks every

15 minutes for the first 7 hours after TPA therapy, hourly for the next 12 hours, and every 2 hours for the next 24 hours.

A general medical floor does not have the personnel to do this type of intensive monitoring, Verro contends. His stroke unit has a three-to-one nurse-to-patient ratio. "You could do it in an intensive care unit (ICU), but stroke unit nurses also are trained to assess neurological deficits. Stroke pa-



Andrea Hidalgo, MD

tients need careful, constant monitoring by trained neurological nurses. A stroke unit is the only appropriate level of care," Verro believes. Also, a stroke unit offers the interdisciplinary care of social workers, physical and occupational therapists, and speech pathologists.

"Studies have shown that a dedicated stroke service is helpful in a patient's prognosis," says Hidalgo. "It reduces

the level of a patient's disability, lowers health care costs, and decreases length of stay."

For a majority of stroke patients, standard treatments, including anti-coagulants and surgical intervention, remain the only option; the new thrombolytic agents have opened up new treatment potentials, empowering physicians for the first time in the battle against a disease that was considered unpreventable and untreatable.

The narrow window available to use the new thrombolytic therapy has physicians emphasizing the importance of taking symptoms of a stroke seriously. "Many people report having a weakness or numbness that they tolerate for hours or even days, hoping the symptoms will go away," says Hidalgo. "Some are not certain what these symptoms mean. If a person has any symptoms of a stroke, medical attention must be sought immediately."

Possible warning signs are a sudden weakness of numbness of the face, arm, or leg on one side of the body; sudden dimness or loss of vision, especially in one eye; sudden difficulty in speaking or understanding speech; sudden severe headache with no known cause; or unexplained dizziness, unsteadiness or sudden falls, especially in combination with other symptoms.

NJM

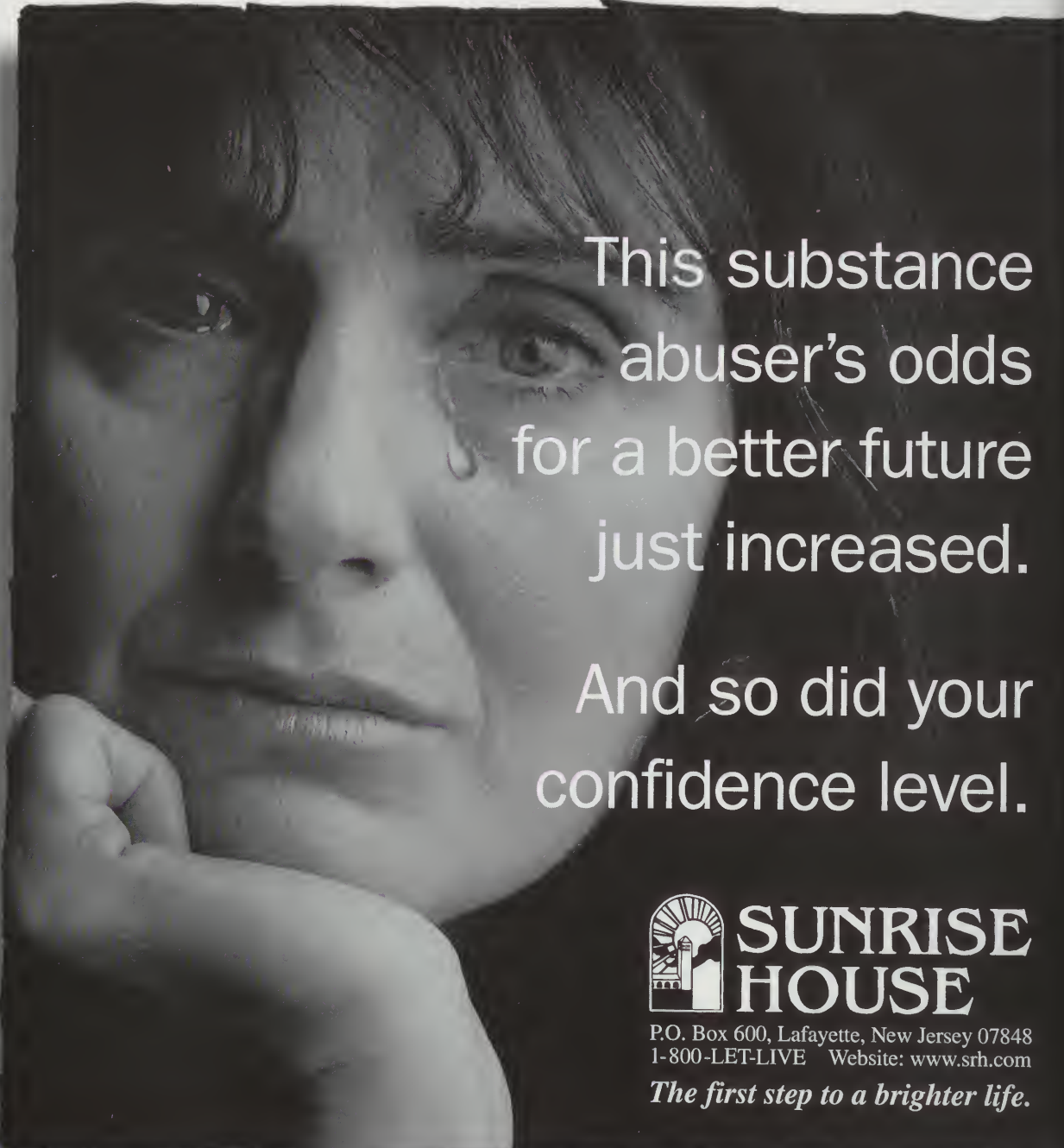
Whether it's an alcohol or drug problem, count on Sunrise House for expert help.

For 14 years, hundreds of tri-state area doctors have trusted us to offer their patients the most effective, caring treatment and a chance for a better life.

Set in the scenic hills of northwest New Jersey, we're a licensed, nonprofit specialty hospital with a nationally known commitment to quality—including Accreditation with Commendation by the JCAHO. Our comprehensive programs include inpatient and outpatient services, after-care and family support.

And our experienced staff of doctors and specialists works closely with referring physicians to ensure continuity of care at every stage of treatment.

Sunrise House. High-quality, affordable treatment you can trust. For information, call us at 1-800-LET-LIVE or (973)383-6300.



This substance
abuser's odds
for a better future
just increased.

And so did your
confidence level.



**SUNRISE
HOUSE**

P.O. Box 600, Lafayette, New Jersey 07848
1-800-LET-LIVE Website: www.srh.com

The first step to a brighter life.

Sunrise House is a preferred provider of most major insurance companies and HMOs.
We will process insurance benefits verification and precertification.

COMMENTARY

The natural role of hospice care at the end of life

Mark Wegryn, MPH

A 75-year-old woman arrived at Father Hudson House, a 25-bed assisted living/hospice residential facility owned and operated by The Center for Hope Hospice. The woman was in the final stages of her terminal illness and was fed through a feeding tube. Sally Sinclair, the nurse manager at Father Hudson House, had the dual responsibility of getting the patient comfortable in her room and allaying any fears held by the patient's son and daughter-in-law.

"The family was very concerned about their mother's condition and their decision to admit her into a hospice facility," said Sinclair. "There is a great deal of uncertainty throughout society about what exactly is hospice care. Families want their loved ones to get the highest level of care and they never want to give up hope."

What is hospice care all about? Since end-of-life issues are making their way into the headlines—due largely, albeit unfortunately, to the exploits of Jack Kevorkian—it is amazing that hospice care has not gained a great deal of national attention. The issues regarding end-of-life care are varied, complex, and difficult. Similarly, neither the scope nor value of hospice care can be fully digested by a definition or an essay. Hospice care also is a subject few people comprehend much less want to discuss openly. The family admitting their mother into Father Hudson House was to receive a crash course.

After completing an initial nursing assessment, Sinclair determined the patient was in poor condition but did seem comfortable. This was consistent with the hospice concept of providing palliative (as opposed to curative) care. After consulting with Chien-Chin Chen, MD, assistant medical director of The Center for Hope Hospice, an initial plan of care was established.

Sinclair's next responsibility was to communicate with the family. She would spend several hours talking about the hospice philosophy and the care provided at Father Hudson House. Before returning home for the evening, the patient's son signed a check, which far exceeded the room and board fee schedule at Father

Hudson House. Financed largely through Medicare, grants, and donations, The Center for Hope Hospice has never turned away a patient based on the inability to pay.

"I would say the family was anxious about the health of their mother—and, to some extent, overwhelmed by the events of the day," said Sinclair. "I also would say that they were relieved because they finally felt their mother was getting the type of care she needed. When the son gave me the check, he told me to keep the balance even if his mother died before the money was spent."

One of the key elements to the hospice concept is the team approach to patient care. The team includes a physician, a nurse, a social worker, a spiritual counselor, and a bereavement counselor. Home health aides and volunteers also play a huge role in the hospice model. The presence of such a cross-section of disciplines allows for each of the patient's clinical, social, and spiritual needs to be met. In the case of a terminal illness, it is important for health care providers to remember that the suffering goes beyond the pain of the diseased individual.

"I believe there is a dichotomy in physicians' attitudes toward hospice care," said Lillian Pliner, MD, medical director of Saint Barnabas Cancer Center, in Union. "For those who frequently attend patients at the end of

life, especially patients with a chronic or disabling illness, hospice care is viewed as a positive, helpful, and comforting experience for patients, families, and caregivers.

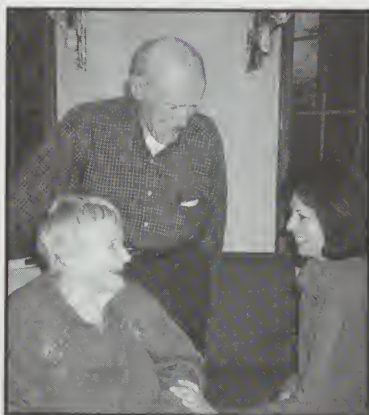
For other physicians, hospice may be viewed as the embodiment of failure—of no longer being successful in treating the disease instead of continuing to treat the patient."

Just 24 hours after entering Father Hudson House, the woman died. Upon hearing the news, a much larger contingent of her family arrived at Father Hudson House and remained for several hours. They were comforted by Sinclair and Bonnie Fee, a member of The Center for Hope Hospice's spiritual department.

"Normally it takes time to gain the trust and acceptance of the families with whom we work. I just met that family the day they lost their mother," said Fee. "But they really opened up. They had a lot of issues they wanted to discuss as a family and they seemed to feel comfortable with me."

"We felt fortunate that we could help this family as much as we did for the two days we knew them," said Sinclair. "In order for the hospice team to do its job, we need to admit the patient much earlier in the dying process."

COMMENTARY



At Father Hudson House, (left to right) Madeline Wood, Bob Applegate, and Dani Lemola, LSW.

COMMENTARY

Pliner, a member of the Medical Society of New Jersey, frequently refers patients to The Center for Hope

Hospice; she believes some physicians must expand their existing paradigm relative to "treating" patients

and their families. All hospice caregivers acknowledge the attending physician as a critical member of the hospice team.

"I think most physicians don't consider hospice their first option when the terminal illness is diagnosed," said Pliner. "A great many physicians have difficulty discussing terminal care and end-of-life issues with their patients. I also think physicians fear losing control of the plan of care for their patients."

One of the biggest issues in this country throughout the 1990s has been controlling costs in the health care system.

"Because of capitation for managed care patients, physicians face financial disincentives if they turn their non-managed care patients over to a hospice program when the terminal illness is first diagnosed," said Pliner.

In this age of quantification, however, it may be important to note the expenses associated with futile end-of-life curative care. An article in the June 1996 edition of *JAMA* stated, "Existing data suggest that hospice and advance directives can save between 25 percent and 40 percent of health care costs during the last month of life." According to information provided by the National Hospice Organization, only \$1.4 billion

of Medicare's \$200 billion budget in 1995 was allocated to hospice care. Medicare, the primary funding source for hospices nationwide, allocated less than 1 percent of its budget to hospice care.

Hospice care is the best option for patients facing terminal illness and their families. When the health care professionals at The Center for Hope Hospice receive overwhelmingly positive feedback from the patients and families in the program, they know they are doing a good job. The Center for Hope Hospice has treated over 6,000 terminally ill individuals and their families since it was cofounded by Margaret J. Coloney and Father Charles Hudson in the late 1970s; it is safe to state that hospice care is an important element of our health care system.

"Despite helping millions of people around the country in the past 23 years, people don't understand hospice because the media would prefer covering more negative, sensationalistic issues," said Coloney, president and CEO of The Center for Hope Hospice. "Too many people are dying—both with cancer and non-cancer diagnoses—without experiencing the gift of hospice because physicians have not developed a comfort level in facing death along with their patients. With the impending issues surrounding assisted suicide currently facing each state, it is time for all persons to evaluate their own priorities about end-of-life care. As health care professionals, it is time to take responsibility for educating the public about hospice."

Mr. Wegryn is public relations director, The Center for Hope Hospice in Linden.

NJM

Only MIIX offers



the Toolkit that fits in your briefcase

Provided by MIIX Financial Services

The MIIX Toolkit, designed specifically for physicians, explains how you can access:

- **MIIX Buying Service** — offering discounts up to 70% on quality medical and office supplies and equipment.
- **Equipment Leasing** — equipment lease financing and lines of credit at competitive rates.
- **Receivables Management** — providing collection of medical accounts receivable.
- **MIIX Capital Management** — investment consulting services for physicians and other high net worth individuals.

To find out more about this powerful resource,
call MIIX Financial Services at

1-800-227-MIIX.

Endorsed by the

Medical Society of New Jersey

MSNJ

MEDICAL INTER-INSURANCE EXCHANGE
POWERFUL PARTNERSHIPS



Computer as menace: Repetitive stress injury

Eric J. Lerner

Computers have proved their value in helping physicians combat illness. Unfortunately, computers also are capable of generating illness. Since the widespread use of computers developed 20 years ago, there has been an accelerating epidemic of repetitive stress injury (RSI) among office workers. While RSI, also referred to as receptive motion disorders (RMD) is a threat to those who do repetitive work in factories or at construction sites, the explosion of data entry and computer-intense jobs has greatly increased the incidence of such injuries, making RSI one of the costliest causes of disability. Over 50 percent of all occupational health problems are due to RSI and the National Institute of Occupational Safety and Health estimates that one in four jobs can cause RSI.

Secretaries, journalists, and others have used typewriters for decades before the development of personal computers and their ubiquitous keyboards. But several factors have combined to make RSI more common with keyboards than with typewriters.

First, keyboarding is more continuous and provides for less breaks in routine than typewriting. A typist would have to stop to change paper, correct errors, or get up and go across the room for a new file folder. Such breaks were crucial in relieving continuous stress on muscles and tendons. In contrast, computer use can involve almost continuous keyboarding and mouse manipulation with no breaks. This unrelenting pressure is exacerbated in jobs where the computer is used to monitor the pace of work, creating high levels of tension that increase the risk of injury.

In addition, the steeply sloping keyboards of typewriters prevented typists from resting their wrists on a surface, so that the large muscles of the upper arm and shoulders did most of the work. Flat computer keyboards with wrist rests increase RSI by magnifying the strain on smaller muscles that are forced to do all the work. Finally, the keys of most keyboards have too little resistance, allowing many typists to thump the key all the way

down. This produces repetitive impacts on finger tips, leading eventually to injury.

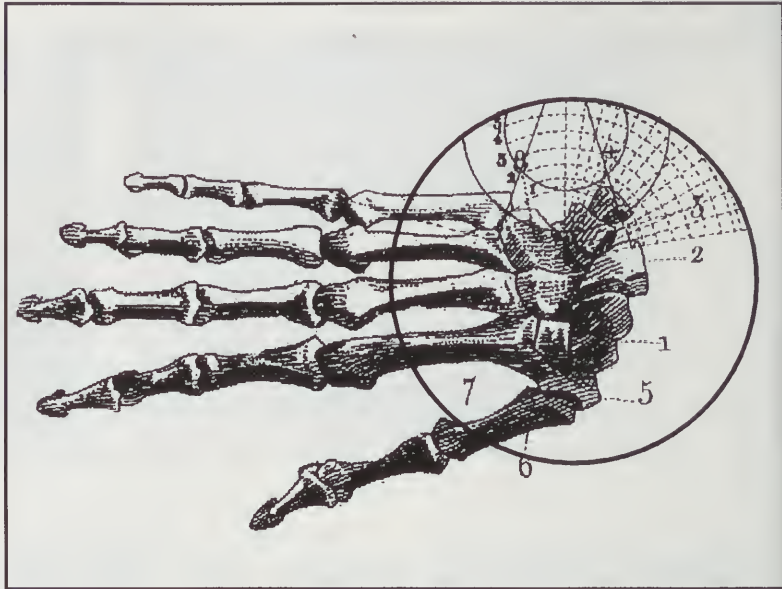
Types of RSI. The basic symptoms of RSI are pain and weakness in the hands, arms, and shoulders. But underlying those symptoms are a variety of distinct disorders, requiring different treatment. Some disorders directly involve the muscles, where myofascial damage occurs from overuse. Many disorders occur when tendons are damaged causing inflammation: tendonitis. Where tendons pass through tendon sheaths, friction between the tendon and sheath can lead to an overproduction of the lubricating fluid called synovial fluid, resulting in the swelling of the sheath and compression of nerves. DeQuervain's disease occurs when the tendon sheath at the junction of the wrist and thumb is swollen, causing acute pain during thumb movement.

In carpal tunnel syndrome, the best known but not the most common form of RSI, the synovium or lining of the carpal tunnel at the base of the wrist is

irritated and compresses the median nerve that services the fingers and the thumb. This causes numbness, tingling, or pain. Carpal tunnel is typically caused by excessive up-and-down finger and wrist motion.

Treatment for RSI involves resting the affected part as much as possible, providing breaks in the work routine, physical therapy, and surgery to relieve pressure and remove scar tissue. Early treatment is critical, since untreated RSI can lead to complications. One of the most serious complications is reflex sympathetic dysfunction where a patient begins to avoid using certain muscles leading to decreased blood flow and more pain. Surgery may worsen RSI, which requires early and aggressive physical therapy to prevent immobilization.

Preventing RSI. RSI is an eminently preventable set of disorders. Experts agree that the most important way of reducing the risk of RSI is to redesign jobs to minimize repetition. In particular, the de-skilling of jobs, concentrating each work on a single task should be avoided. Employers and physicians, especially those in practices with large demands for keyboarding,



should make sure that job descriptions include varied work, not focusing any worker exclusively on computer input.

In addition, proper design of the work environment is essential. Contrary to widespread belief, the best orientation for the keyboard is sloping slightly away from the user, with wrists straight and level, not touching any supports. Keyboards should be set low, so that the users forearms are parallel to the floor. In action, keyboarders should be instructed in correct technique, ensuring that wrists are straight, not turned outward, and are held in a neutral position. In using a mouse, the wrist should not be supported, allowing the upper arm muscles to move the

mouse—the wrist and fingers should be essentially passive.

New technology can be used to reduce the need for keyboarding altogether. Speech recognition programs, some aimed specifically at physicians, are allowing direct dictation of notes into the computer. Documents now can be scanned into a computer without the need for re-keyboarding, or can be sent in electronic form.

No matter what the technology, repetitive tasks have to be avoided. Talking into a computer all day can be as hard on the vocal cords as keyboarding is on the fingers and wrists. In workplace safety, as elsewhere, variety is more than the spice of life—it's essential.

The Original

PHILADELPHIA
BOARD REVIEW
COURSE IN
CARDIOVASCULAR
DISEASESSM

Tuesday-Sunday
October 13-18, 1998

Sponsored Annually by



co-sponsored by
Council on Clinical Cardiology of the



Location: Wyndham Franklin Plaza Hotel
Philadelphia, PA

Why Should You Attend This Board Review Course!

- The Original Philadelphia Cardiovascular Board Review...offered since 1983
- Over 90% pass rate!
- More days, more hours, more lectures, more topics than other courses
- Geared exclusively for taking the Boards; contains all the required subjects, no research or esoteric topics
- Most Comprehensive Course Syllabus
- Fee includes continental breakfasts, luncheons, breaks, exhibits, and evening sessions
- Low hotel rates - close to great restaurants, shopping, theaters, museums, and sports venues
- Course faculty of nationally-known scholars

This program is designed to provide the physician with an intensive in-depth review of the clinical manifestations, pathophysiology, and treatment of cardiovascular diseases.

Allegheny University of the Health Sciences, MCP•Hahnemann School of Medicine is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians. Allegheny University of the Health Sciences, MCP•Hahnemann School of Medicine designates this educational activity for a maximum of 50.0 hours in category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

This program is eligible for 50.0 credit hours in category 2A of the American Osteopathic Association.

All faculty participating in continuing medical education programs sponsored by Allegheny University of the Health Sciences, MCP•Hahnemann School of Medicine are expected to disclose to the audience any real or apparent conflict(s) of interest related to the content of their presentation.

Call 215-762-8264 for information or a brochure.

FOCUS JOSEPH T. HAYES,

M.D., M.P.H., M.S.M., F.A.C.P.M.
Associate—Specializing in Physician
Business and Financial Planning

Licensed in Securities & Insurance

CALL FOR A FREE CONSULTATION AND BROCHURE

**732-831-0300 or
1-800-774-1734**

Focus Financial Group, Inc.

Registered Investment Advisor
P.O. Box 4516

Metuchen, New Jersey 08840-4516

REGISTERED REPRESENTATIVE OF
CADARET, GRANT & CO.

200 Valley Road, Mt. Arlington, NJ 07856

Member NASD/SIPC

THE RIGHT PRESCRIPTION
FOR YOUR
CALLERS



Message-On-Hold Systems

Use your telephone music-on-hold feature to:

- Promote Services
- Reassure Callers
- Educate & Inform
- Encourage Referrals

HOLD COM

Serving the NJ Healthcare Industry Since 1987

Call 1-800-666-6465

<http://www.holdcom.com>

calendar

APRIL, MAY, & JUNE '98

**Urology Society
Medical Grand Rounds**
April 15, 22, and 29, 1998
VA Medical Center, East Orange
973/982-6170

**Radiological Society/Institute
of Ultrasound in Medicine**
April 16, 1998
St. Barnabas Medical Center, Livingston
973/533-5822

General Internal Medicine
April 21, 1998
UMDNJ, New Brunswick
732/235-7430

**New Clinical Trials in
Transplantation**
April 21, 1998
Overlook Hospital, Summit
AMNJ, 609/275-1911

Pediatric HIV Infection
April 21, 1998
South Jersey Hospital, Elmer
AMNJ, 609/275-1911

Pediatric Trauma Conference
April 21, 1998
UMDNJ-RWJ Med School
732/235-7430

**Orthopaedic Society
Annual Meeting**
April 21-26, 1998
Palm Springs, CA
AMNJ, 609/275-1911

Urology Society Awards Dinner
April 22, 1998
The Manor, West Orange
AMNJ, 609/275-1911

Critical Care Medicine
April 22-26, 1998
Washington, DC
201/385-8080

**Radiology Visiting
Professor Lecture**
April 23, 1998
St. Barnabas Medical Center, Livingston
973/533-5803

**Hospice and Palliative
Care Workshop**
April 23, 1998
Stark & Stark, Lawrenceville
908/233-0060

MSNJ Annual Meeting
April 28-May 2, 1998
Trump Taj Mahal Casino, Atlantic City
609/896-1766

**Ambulatory Ob/Gyn and
Reproductive Serv.**
May 1-2, 1998
UMDNJ-RWJ Med School
732/235-7430

Eastern Vascular Society
May 1-3, 1998
Newport Marriott Hotel, Newport, RI
AMNJ, 609/275-1911

Endocrinology Lecture
May 6, 1998
VA Medical Center, East Orange
973/676-1000 x1311

**Interhospital Endocrine
Rounds**
May 6, 13, 20, and 27, 1998
University Hospital, Newark
973/982-6170

Medical Grand Rounds
May 6, 13, 20, and 27, 1998
VA Medical Center, East Orange
973/982-6170

Head and Neck Oncology
May 14, 1998
The Manor, West Orange
AMNJ, 609/275-1911

**Pathology of Hemodialysis
Access Dysfunction**
May 19, 1998
Overlook Hospital, Summit
AMNJ, 609/275-1911

**Society of
Anesthesiologists Meeting**
May 19, 1998
Forsgate Country Club, Jamesburg
609/275-0083

Radiological Society
May 21, 1998
UMDNJ-RWJ Medical School
732/235-7721

**Opportunistic Infections in the
Respiratory System**
May 22, 1998
Newcomb Medical Center, Vineland
AMNJ, 609/275-1911

Radiology Lecture
May 28, 1998
St. Barnabas Medical Center, Livingston
973/533-5803

Ob/Gyn Soc. Annual Mtg.
June 5-7, 1998
Trump Plaza Hotel, Atlantic City
AMNJ, 609/275-1911

**Oncology Society
Annual Meeting**
June 10, 1998
Hyatt Regency, New Brunswick
AMNJ, 609/275-1911

12th World AIDS Conference
June 28, 1998
Geneva, Switzerland

**MSNJ
Annual Meeting**
April 28-May 2, 1998

18th Annual Emergency Medicine Seminar

Contemporary Concepts in Clinical Emergency Medicine: A Literature-Based Approach

Wednesday - Friday, June 3-5, 1998

This seminar encompasses the spectrum of disease represented by Emergency Medicine. A diverse selection of scenario-based topics will be discussed using an evidence-based approach. Each faculty member will develop a state-of-the-art presentation which will offer registrants a rational, literature-based approach to clinical issues requiring decision making in the ED. The registrants will be afforded well researched presentations and the ability to discuss and debate current clinical perspectives, management options and treatment protocols.

Fee: \$450

Accreditation: 21 Category I Credit hours AMA

For information write or phone:
NYU Post-Graduate Medical School
50 First Avenue,
New York, N.Y. 10016
(212) 263-5295



Post-Graduate Medical School

JM

Specializing in the Business of Health Care

Physician Practice Assessment/Contract Negotiations
Fee Schedule & Super Bill Analysis/New Practice Set-Up
Coding Issues/Risk Management

Call Evelyn Gross, CMM, CPC
(201) 261-4030

HUNTER HEALTHCARE SERVICES

Division of RD Hunter & Company LLP
Paramus, NJ New York City

June 8-12th, 1998

Update Your Medicine twenty-fourth annual practical CME course with lectures, workshops, and Meet-the-Professor luncheons. Sponsored by Cornell University Medical College in New York City and the Association of Practicing Physicians of The New York Hospital. 37.25 Category 1 AMA-PRA credit. Additional 11½ credits available for Hands-on Workshops. This program has also been reviewed and is acceptable for 37.25 prescribed hours by the American Academy of Family Physicians. Information: Lila A. Wallis, MD, Director and Debora A. Laan, Coordinator, 445 East 69th Street, Olin-Room 328, New York, NY 10021. Telephone: 212-746-4752.

Saturday, June 27, 1998

18th ANNUAL Advances in Gastroenterology Course

Trump Plaza/World's Fair
Atlantic City, New Jersey

Course Director:

Anthony J. DiMarino, Jr., MD

For more information, please call
(609) 848-1000

Registration Department



Thomas
Jefferson
University

Jefferson
Medical
College

Jefferson Medical College of Thomas Jefferson University, as a member of the Consortium for Academic Continuing Medical Education, is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing education for physicians. As usual, CME credits will be offered.

Practical Issues in Cancer Genetics

Thursday, May 28, 1998

**Princeton Marriott Forrestal Village
Princeton, NJ**

8:00 a.m.-5:00 p.m.

Featured Faculty

Daniel Burk, JSM, JD, Seton Hall University
Charis Eng, MD, PhD, Dana Farber Cancer Institute
Judy Garber, MD, Dana Farber Cancer Institute
Monica Magee, MS, UMDNJ-Robert Wood
Johnson Medical School

Kenneth Offit, MD, Memorial Sloan Kettering Cancer Center
T.S. Ravikumar, MD, The Cancer Institute of New Jersey
Amy Strauss Tranin, RN, MS, OCN,
The Cancer Institute of Health Midwest
Deborah Toppmeyer, MD, The Cancer Institute of New Jersey

Sponsored by

**American Society of Clinical Oncology
The Cancer Institute of New Jersey
The New Jersey State Commission on Cancer Research
and the Oncology Society of New Jersey**

For more information call:

(732) 235-6786 or (609) 633-6552

**The collision of medicine, governmental regulations on fraud
and abuse, law, and business. The ethics of survival
and the survival of ethical practice.**

**April 30, 1998
10 a.m.-12 noon**

Trump Taj Mahal Casino/Resort, Atlantic City, NJ

Sponsored by the MSNJ Committee on Biomedical Ethics and
The Academy of Medicine of New Jersey

- This program brings experts in business, law, and ethics together to address hard realities of today's world of medicine.
- Organized medicine is struggling to protect the essential triad of medicine as art, science, and humanity. On the other hand, parts of government and business see delivery of health care simply as a commodity; a "service" easily manipulated, policed, and audited.
- To survive and maintain medicine's quality, physicians must understand the reality of market forces. They also must understand the laws, policies, and actions of regulators.
- Physicians must know not only their responsibilities, but also when their rights are jeopardized—and where to turn for skilled legal advice and protection.

OBJECTIVES: As a result of attending this program, participants should be able to

- Better understand the complex relationships between technology, a market economy, government, and medicine.
- Better respond to the increasing complex demands of government and business in their day-by-day activities.
- Redefine their ethical and legal obligations.
- Adjust their practice patterns to better reflect the reality of finite resources in a third-party payor system.

Keynote speaker:

William J. Ellos, PhD

"Working the Practice and Playing the Profits"

Prof. Ellos has doctorate degrees in both medical and business ethics and is affiliated with the University of Chicago, Cambridge University, University of Texas Health Sciences, and Motorola Corporation.

Other Speakers:

Steven I. Kern, Esq, Robert J. Conroy, Esq, of Kern, Augustine, Conroy and Schoppmann, P.C.
Janet Nolan, Esq, Asst. United States Attorney for the District of New Jersey
and Deputy Attorney General

Introductions and summary by Paul W. Armstrong, Esq and
Joseph F. Fennelly, MD, chair, MSNJ Committee on Biomedical Ethics

We know that practicing medicine is your primary concern.

The professionals at Healthcare Management Partners will take away the time-consuming administration and pressures of billing, collections, follow-up, office management, and system maintenance, so you can concentrate on doing what you do best - practicing medicine.

Contact Rosalie Fox or Robert Rahl at 609-734-0443 to find out more.

**Practice Assessments • Billing & Collection •
MIS Systems • Group Practice Formation •
Practice Management • Income Distribution**

**Endorsed Computerized Billing,
Accounts Receivable and
Information Management Company of the
Medical Society of New Jersey**



HEALTHCARE MANAGEMENT PARTNERS

PARTNERS IN PROFIT

200 Canal Pointe Boulevard • Princeton, NJ 08540-5998
609-734-0443 • FAX 609-243-9799

A Division of Health Information Consulting Services, Inc.

New Jersey MEDICINE

SPECIAL EDITION: May 1998

NEW JERSEY

The Nation's Medicine Chest

New Jersey is the global leader in the pharmaceutical and medical device industry. Find out how this leading New Jersey industry has impacted the world.

The May issue of *New Jersey MEDICINE* will feature a look into the high-tech pharmaceutical and medical device industry in New Jersey.

- ◆ New Jersey as the world leader
- ◆ Groundbreaking R&D
- ◆ Positive partnerships
- ◆ Dollar and cents impact
- ◆ The "good neighbor" approach

To order additional copies
contact *New Jersey MEDICINE*
609/896-1766

Practicing medicine
= good

Practicing running
a business
≠ good

*Practice management and
practice efficiency solutions
from professionals with
hands-on experience*

WITHUM, SMITH & BROWN
Certified Public Accountants & Consultants
Health Services Department

100 Overlook Center

Princeton, NJ 08540

609-520-1188

<http://www.withum.com>

Offices in New Jersey and Pennsylvania



ATAC Accounting for Time,
Activity, and Cost

MEMBER NEXIA INTERNATIONAL
A WORLDWIDE NETWORK OF
INDEPENDENT ACCOUNTING FIRMS



OF NORTH JERSEY & NEW YORK

is now

ImageFIRST™
MEDICAL WEAR

Lab Coats ■ Dentists Jackets
Patients Gowns ■ Towels ■ Sheets
Pillow Cases ■ And More!

*Changing and improving our
service for you!*

For information call:

1-800-368-3676



All The Doctors...

Who Use Us For Accounts Management

**Found Us To Be Invaluable
in Safeguarding Their Income**

- H.M.O. Claims Verified and Finalized
- Compensation and No-Fault Cases Settled
- Patient Balances and Self-Pay Accounts Collected

Cut Office Costs

Eliminate:

- In-House Collection Expense
- Your Office Staff's Endless Hours on the Phone with Insurance Companies
- The Constant Follow-Up With Patients That Promise to Pay Balances

To Get More Information About Our Company Call:

Client Contact Company
1(800) 645-2303

E-mail: MedmanCo@AOL.com • FAX 1(800) 473-1184
2949 Long Beach Rd., Oceanside, N.Y. 11572

CLASSIFIED ADS

100 OPENINGS PHYSICIANS (MULTIPLE SPECIALTY LISTINGS)

THE PODELL MEDICAL CENTER

New Providence Holistic Health Center: Seeking collaboration from well-trained physicians from all specialties. Especially Women's Health: also Pediatricians or Family Physicians to help develop program for A.D.D. children. Contact Dr. Podell 908-464-3800 or fax 908-464-3078.

FULL TIME PHYSICIANS

Full Time Physicians needed for Group Practice. Excellent potential. Please call 732-892-4141.

110 OPENINGS PHYSICIANS

DERMATOLOGY PRACTICE OPEN OPPORTUNITY

Thriving well-established practice on Jersey Shore seeking energetic individual to assume practice. Can also accommodate P/T work, 1-2 days/wk; terms negotiable. Confidential Box #137, c/o NEW JERSEY MEDICINE, 370 Morris Avenue, Trenton, NJ 08611.

BC/BE DERMATOLOGIST

Large Primary Care Group in Red Bank area needs a Part-time Dermatologist. Flexible schedule. Growth Opportunity. FAX CV 732-219-1968 or call 732-747-4600.

BC/BE INTERNIST/INFECTIOUS DISEASES SPECIALIST

BC/BE Infectious Diseases Specialist for busy practice in Central NJ. Competitive salary and benefits package, Fax CV to 732-203-0311.

BC/BE PEDIATRICIAN CAPE MAY COUNTY

To join pediatric group practice. Competitive salary. Early partnership. Please send CV to Cape Pediatric Associates, P.A., 301 Dennisville Rd., Cape May Court House, NJ 08210.

FAMILY PRACTICE MORRIS COUNTY

Excellent opportunity for a physician to join an established Family Practice in Morris Plains, Morris County, New Jersey. Salary commensurate with experience. Will introduce. Terms available. Please fax resume ATTN: FAP (516) 665-0555.

PRIMARY CARE MONMOUTH COUNTY

Family Practice physician needed F/T to join our expanding group practice. Ideal candidate will possess board certification in primary care along with some emergency care experience. Primary responsibility will be providing office care. Monmouth County location. Please respond with C.V. to Robert A. Rosen, MD, P.O. Box 8340, Red Bank, NJ 07701, or by fax to 732-219-0108.

130 OPPORTUNITY WANTED

FAMILY PRACTICE

Board Certified Family Practitioner looking for F/PT Practice Opportunity. Prefer Camden or Burlington Counties but willing to relocate. I am a hard working and dedicated Physician. Write 31A W. 2nd Street, Florence, NJ 08518 or call 609-499-8678.

170 OPENINGS—STAFF

MANAGER/ADMINISTRATOR ATLANTIC COUNTY

Large, multi-location OB/Gyn practice in Atlantic County seeks individual with proven administrative and management skills. Responsible for overall operations including financial, utilization, data processing, billing and claims functions. Call Mr. Rubin 609-652-1453, Ext. 12.

200 PRACTICE FOR SALE

FAMILY PRACTICE

Twenty year old, well established exclusively Spanish population, primary care in a busy city area, for sale. Great opportunity for dedicated MD committed to quality care. Major HMO affiliated. Please call 973-484-5887 between hours of 11 AM to 3 PM.

ORTHOPAEDIC PRACTICE

Active Orthopaedic practice for sale—NE NJ (Suburban NYC Area)—in 1998. Differed financial incentives available for new Orthopaedist. Write: POB 4724, Clifton, NJ 07015.

300 OFFICE RENTALS AND LEASES

EDISON

Office Space—Edison Medi-Plex Building opposite J.F.K. Hosp. Fully equipped, turn key. Rent: day, half day, night. 732-494-6300.

HILLSBORO

Hillsboro Medical Office—1,500 sq. ft. \$1,000/mo. Busy location. Active practices in building. Ideal for new or 2nd practice. Call Dr. Wolinsky 212-476-7789 days or 215-860-8491 eves.

MILLBURN

Medical Arts Building, Millburn Avenue. Fully equipped, turn key. Rent day, 1/2 day, night. Call 973-376-8670.

MOORESTOWN

Several offices available in Medical Complex. Various sizes. Excellent location. Stanley R. Lane, MD 609-235-2651.

310 OFFICES TO SHARE

FORT LEE (BERGEN COUNTY)

Established 15 yr. Chiropractic Practice—Interested in sharing a 1600 Sq. Ft. spacious, modern office with 5 treatment rooms. Located in a residential area of Fort Lee—5 minutes from G.W.B. Turnkey Operation. 201-886-8755.

MARLBORO

Share medical office space with Internist Family Practitioner in Marlboro on Route 1. Prime location. Affluent area. Major shopping centers and many retirement communities closeby. Busy ENT next door. 2 exam rooms available. Abundant parking. Wheelchair accessible. Any Subspecialty welcome. Won't leave. Call 732-617-8800.

PRINCETON AND/OR MARGATE

Princeton and/or Margate space to share bright, dynamic rehab. center. Flexible schedule depending on needs. Call Vandy 609-581-2400.

325 MEDICAL BUILDING FOR SALE OR LEASE

LAWRENCEVILLE

2300 sq. ft. Condominium Professional Building Close to Rt. 1 corridor. Four exam rooms, two consultation rooms. Large work areas. Wheelchair accessible bathroom. Two lab rooms. Lounge, storage space built-in. File room. Private entrance in rear. Purchase or Lease anytime between 9:00 a.m. and 3:00 p.m. Call 609-896-0242.

MOUNTAINSIDE, NJ

Medical Space Available. 1055 Rt. 22—1,000 sq. ft. for sale or lease—divisible. 200 Shepley St.—7,000 sq. ft. for lease—divisible. 145 Rt. 22—4,000 sq. ft. & 3,629 sq. ft. for lease. Easy access/highway frontage/priced aggressively. Call David Simon at 732-750-4000 ext. 119. GSI Company, L.L.C. Exclusive Broker.

415 MEDICAL BILLING

North American Financial Systems, Inc. Affordable medical billing company. Call Mike for more information. 973-535-0654.

420 FINANCIAL SERVICE

ALTERNATIVE FINANCING/MEDIATION

Where do you go when banks say "NO"? Our company has access to an extensive network of Alternative lenders willing to go where traditional banks won't. Business Debts that are overdue can cause real problems. We reduce debts by skillful negotiation. 732-416-0100.

510 EQUIPMENT WANTED

USED DEXA MACHINE

Wanted: A used Dexa (Bone Density Machine). Preferably a Hologic. Cash or Installment. Please call 24 hours, Page 421-9795 or 609-586-1100 or Eves 609-924-4704 for the doctor.

900 MISCELLANEOUS

OFFICE FURNITURE

In room cabinets, business desk, 12' second wall unit (bookcase) ... and more. All excellent condition. Fort Lee. 201-886-8755 Dr. Koziel.

HOUSING APPLICATION
232ND ANNUAL MEETING
MEDICAL SOCIETY OF NEW JERSEY
APRIL 28-MAY 2, 1998

TRUMP TAJ MAHAL CASINO/RESORT

1000 BOARDWALK AT VIRGINIA AVENUE, ATLANTIC CITY, NJ 08401

RESERVATION DEPARTMENT 1-800-825-8888

(Please Print)

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Sharing With _____

Date of Arrival _____ Time _____

Date of Departure _____ Time _____

A one-night deposit (equivalent to room rate) is required with all reservation requests. Please send check or money order payable to the **TRUMP TAJ MAHAL CASINO/RESORT** or complete the following:

Card # _____ Type _____ Exp. Date _____

SCHEDULE OF RATES SUBJECT TO 12% TAX, PLUS \$2 PER ROOM, PER NIGHT

() SINGLE \$118.00 () DOUBLE \$118.00 EXTRA PERSON \$25.00

Reservations must be received prior to MARCH 30, 1998.

() One-Bedroom Suite \$275.00 per day () One-Bedroom Hospitality Suite \$350.00 per day

Check-out time is 12 Noon. Rooms may not be available for check-in until after 4 p.m. Check-in time on Sundays is 6 p.m. FORTY-EIGHT (48) HOURS NOTICE OF CANCELLATION is required for a full refund. PARKING: There is a state-imposed \$2.00 minimum charge per 24-hour period for each motor vehicle parking on the premises.

() Check if Official Delegate _____ County _____

PLEASE NOTE: Current state sales tax is 3% and occupancy tax is 9%, and room usage fee is \$2.00 per room, per night. These taxes are subject to change, without notice.

The proceeds from the fees collected shall be paid into a special fund which will be established and held by the Atlantic City Convention Center Authority. Amounts in the special fund shall be expended by the Convention Center Authority solely for the purposes of promoting tourism, conventions, resorts and casino gaming.

MAIL THIS APPLICATION TO: Reservations
Trump Taj Mahal Casino/Resort
1000 Boardwalk at Virginia Avenue
Atlantic City, NJ 08401

Housing Application online at www.msnj.org

EMERGENCY PHYSICIANS

Emergency Physician Associates, a Team Health affiliate, is seeking quality ED physicians for a variety of practice opportunities in NJ, PA, MD, NC and NY.

We offer physicians competitive compensation, flexible schedules, malpractice insurance, a variety of practice settings, and supportive Medical Directors.

Interested candidates may call

1-800-848-EPA-1.

MEDICAL OFFICE CONDO TO SUBLET IN HAMILTON TOWNSHIP

Modern Fully furnished, 1600 sq. ft., utilities included.

Available immediately for 3½ days per week.
(All day Tues., Wed., & Fri.; after 1 p.m. on Thurs.)

Plenty of onsite parking available

For more information

Call Margaret at:

(609) 921-2202, ext. 244

BERGEN COUNTY



This solid brick 4,775 sq ft bldg is perfect for growing medical office. Full bsmt for storage; on site parking. Loc btwn Hackensack Medical Center & Holy Name Hospital, Rt 80. AVAIL FOR LEASE/PURCHASE.

Absolutely beautiful . . . must be seen!

RIOTTO ASSOCIATES

Realtors since 1954

201-833-0600

THE MEDICAL SOCIETY OF NEW JERSEY CLASSIFIED ADVERTISEMENT RATES

(Placement in New Jersey *MEDICINE* OR on WEB Site)

New Jersey *MEDICINE*

<http://www.msnj.org>
WEB Site

Per Month—Non-Members

Minimum 45 words	\$ 45.00
plus each word over 45 words	\$ 1.00

Per Month—Members

Minimum 45 words	\$ 30.00
plus each word over 45 words	\$ 1.00

Per Month—

Minimum 45 words	\$ 45.00
plus each word over 45 words	\$ 1.00

(Placement in New Jersey *MEDICINE* AND on WEB Site)

New Jersey *MEDICINE*

<http://www.msnj.org>
WEB Site

Per Month—Non-Members

Minimum 45 words	\$ 45.00	\$ 36.00
plus each word over 45 words	\$ 1.00	\$.80

Per Month—Members

Minimum 45 words	\$ 30.00	\$ 36.00
plus each word over 45 words	\$ 1.00	\$.80

PREPARE YOUR COPY ON A SEPARATE PAGE AND ATTACH TO THIS ORDER FORM

I'm on the MSNJ Physician Finder.

Are you?



*Carl Restivo, Jr, MD
MSNJ President*

The Physician Finder:

- Showcases and markets my practice.
- Offers a comprehensive overview about my office.
- Presents detailed information for referrals.

The MSNJ Physician Finder is an electronic directory of active MSNJ members. You can find the Physician Finder on MSNJ's web site:

www.msnj.org

For more information about the Physician Finder
call MSNJ, 609/896-1766 ext. 259.

The **MSNJ Physician Finder** is the place to turn
for information about MSNJ physicians.

The best doctors and nurses.

Diann Johnston, R.N., M.S.N.
Senior Vice President
Patient Care Services

Luis A. Gonzalez, M.D.
Internal Medicine/Cardiology

Herbert Egbuna, M.D.
Pediatrics

John Hosay, Jr., M.D.
Urology

Henry Fernandez-Cos, M.D.
Obstetrics and Gynecology

Letitia Luna, M.D.
Cardiology

Doreen Lallo, R.N.F.A.
Department of Surgery

Right in your neighborhood.

Where do you find the best doctors and nurses in Hudson County? Our doctors are highly-skilled, caring professionals, many of whom are recognized experts in their fields. And every nurse is an R.N. That's why so many rate above the national average for providing excellent care.

Call (201) 418-2020.

**ST. FRANCIS
HOSPITAL**
of Jersey City

**ST. MARY
HOSPITAL**
of Hoboken

 Franciscan Health System of New Jersey, Inc.

Member: Franciscan Health Partnerships, Inc.

continued from page 80

Preferred services

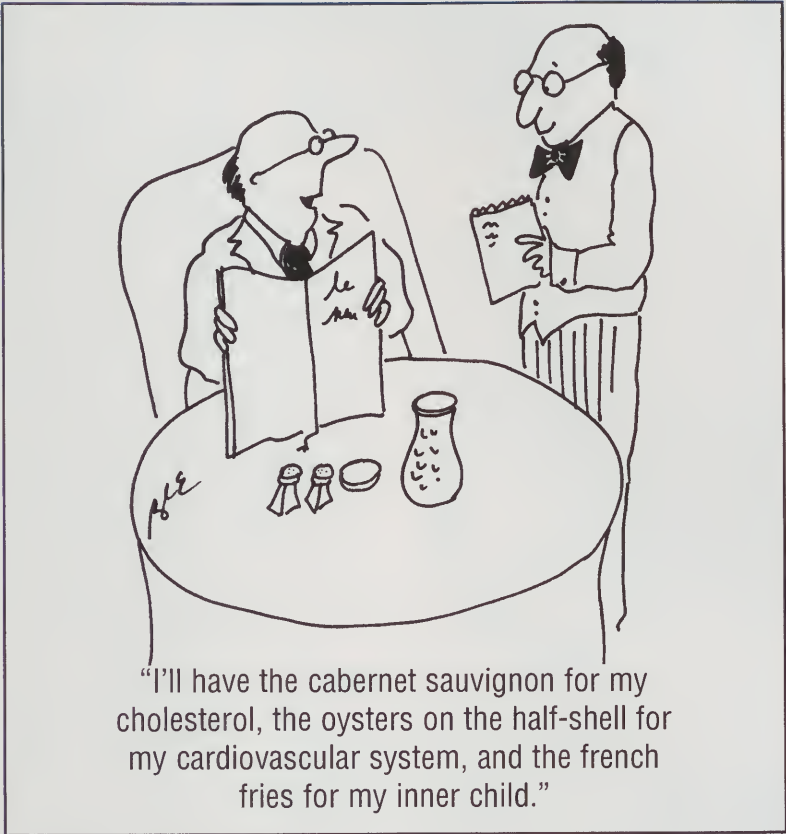
MIIX Preferred Purchasing Alliance (formerly Buying Services) has added MedConnect and PRN Technologies to its list of discounted services. MedConnect offers an efficient communications solution for physicians, whereby physicians can leave messages for their patients such as test results, referrals, nursing home reports, and followup information; patients can retrieve their doctor's personal message. Physi-



cians and patients access this service at any time using a toll-free number. PRN Technologies' user-friendly Medical Information Solutions (MIS) program is designed for practice management. MIS allows patient record keeping, scheduling, medical history, paper and electronic billing, accounting, requisition for diagnostic tests, and report capabilities. For more information, contact MIIX Preferred Purchasing Alliance at 800/227-MIIX.

Worth a thousand words

Beginning next month, we will be inaugurating a new column in *New Jersey Medicine*. This page, called Photo Finish, will be dedicated to medical moments in time: photographs that capture the essence of health care. We welcome contributions to Photo Finish. Photographs (black and white or color) should be sent to Geraldine Hutner, *New Jersey Medicine*, Two Princess Road, Lawrenceville, NJ 08648. Include a 50-word description of the picture. Photographs will be returned.



TV with a twist

Patients at Saint Barnabas Medical Center now can use T.V. Reader to keep up with the daily news or enjoy a novel. T.V. Reader helps patients who are permanently or temporarily unable to read newspapers, magazines, or novels. Stroke patients, who are physically unable to turn the pages benefit from T.V. Reader, says Jan Ball, a staff member in the Patient Representative Department. Broadcast to patients' rooms over Saint Barnabas' closed circuit television, T.V. Reader offers segments of daily readings from newspapers, magazines, and other periodicals, including *The Star-Ledger*, *The New York Times*, *TV Guide*, *The New Yorker*, and current novels.



Patient Mary Sanders enjoys T.V. Reader.

© Tracy Bischoff



ACTION AT THE ANNUAL MEETING

Spring is in the air and so is the MSNJ 232rd Annual Meeting, scheduled for April 28-May 2, 1998, at the Trump Taj Mahal Casino/Resort, in Atlantic City. Highlighting the meeting will be the inauguration of R. Gregory Sachs, MD, on May 1, as the new president of MSNJ. Sachs, a cardiologist, is a member of the Union County Medical Society and of the AMA.

Other programs include The Academy of Medicine of New

Jersey's Roving Symposium™, "Elder Mistreatment: Identification, Assessment, and Intervention" and the MSNJ Committee on Biomedical Ethics' education program focusing on new anti-fraud laws. The Golden Merit Award Ceremony, on April 30, will commemorate members who have held the degree of medical doctor for 50 years.

The MSNJ Alliance will be holding its annual meeting in conjunction with MSNJ. The MSNJ Alliance will install its new president, Valerie Claps. Two special events include the art show and the tennis fundraiser to benefit the American Medical Association's Education and Research Foundation.

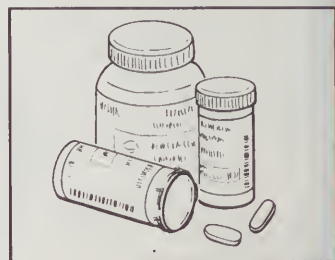
For more information, call Peggy Johnson at MSNJ, at 609/896-1766, extension 252.



President Dr. Restivo and incoming president Dr. Sachs.

New Jersey's medicine chest

Referred to as the medicine chest of the nation, New Jersey is the core of the pharmaceutical and medical device industry. In the May issue, *New Jersey Medicine* will present an in-depth look into this high-tech industry. Read about the groundbreaking research and development that's going on in our state; delve into the pharmaceuticals "dollars and cents" effect on the state economy; learn about the "good neighbor" approach of many New Jersey pharmaceuticals. Two copies of this issue will be sent to all MSNJ members: one copy for the physician-member and one copy for the waiting room.



Policy update

Please note the following correction in the MSNJ 1998 *Policy Compendium*. The policy under the section heading, Biomedical Ethics, should read as follows:

10.993 Withholding and withdrawing of medical treatment. MSNJ supports legal action to challenge the BME policy that patients must be evaluated by two nonattending physicians to determine their competency to accept or decline life-sustaining medical treatment. (BOT 3/96).

Free breast cancer resource

The National Alliance of Breast Cancer Organizations is providing a free card that lists breast cancer resources. This quick and easy guide lists services and programs offered by the top breast cancer organizations across the nation. The guide is appropriate for patients, physicians, and other health care providers. Free copies are available by calling 1/800-610-5757.

continued on page 79

For every woman concerned about breast cancer...

Women with breast cancer and those at high risk for breast cancer need information and support. Here are the needs most frequently expressed and the free resources most often requested by the National Alliance of Breast Cancer Organizations (NABCO).

Who can I turn to for the risk of developing breast cancer and its detection and treatment? Who can give me a high-quality mammogram?

NABCO's National Alliance of Breast Cancer Organizations (NABCO) is a national, non-profit organization that provides information and support to women with breast cancer and those at high risk for breast cancer.

Who provides professional counseling to breast cancer patients and their families?

NABCO's Cancer Care Inc. is a national, non-profit organization that provides professional counseling to breast cancer patients and their families.

How do I get information on breast cancer support services?

NABCO's National Breast Cancer Organization is a national, non-profit organization that provides information and support to breast cancer patients and their families.

How do I get information on breast cancer support services?

NABCO's National Breast Cancer Organization is a national, non-profit organization that provides information and support to breast cancer patients and their families.

How do I get information on breast cancer support services?

NABCO's National Breast Cancer Organization is a national, non-profit organization that provides information and support to breast cancer patients and their families.

NEW JERSEY MEDICINE

HEALTH CARE IN THE GARDEN STATE

MAY 1998

Cure Quest

*Getting it
from the lab
into your
medicine chest*

Pills & Priorities

*Pharmacists
face off with
managed care*

Y - O - U - R

PRACTICE

MADE MORE

PERFECT

WITH OVERHEAD EXPENSE INSURANCE FROM BLANKSTEEN

If you get sick, we'd like to help keep your practice well with overhead expense coverage that can reimburse office salaries, rent, insurance premiums, and utilities during an extended disability. Your needs are special, so call and talk with us. The only time to draw a blank in your insurance is when you fill it in with Blanksteen.



The ----- steen Companies

The Blanksteen Companies 253 Washington Street Jersey City, NJ 07302 201-333-4340 1-800-BLANK-AG
The Blanksteen Companies 161 William Street New York, NY 10038 212-732-9435 1-800-BLANK-AG
The MEDICAL SOCIETY OF NEW JERSEY endorsed plans, including Professional Overhead Expense underwritten by National Casualty Company.

JUL 13 1998

AUSTIN, TEXAS

Health benefits for New Jerseyans and life in the Legislature

The state's largest business lobbying group, the New Jersey Business and Industry Association (NJBIA), released its 1997 Health Benefits survey. The good news is that 94 percent of all companies responding provided health benefits coverage to full-time employees, a number that has grown from 87 percent in 1987. The average cost of a health policy to employers was \$4,106 per covered employee, an increase of 2.9 percent from 1996.

Eighty-four percent of all plans in use by employers in 1997 were less expensive managed care plans, double the 42 percent share enjoyed by managed care just three years ago.

New Jersey employers' preferences of plan types now closely mirror the preferences of employers across the country. The NJBIA survey found that 16 percent of companies buy conventional fee-

for-service insurance; 31 percent, HMO; 31 percent, preferred-provider; and 22 percent offer a point of service.

May finds the New Jersey Legislature returning from its traditional April hiatus, where only those involved with crafting the state's budget are left in town to discuss the numbers. This April, however, the Legislature tackled the state's most pressing issue—lowering the highest automobile insurance rates in the country. As we go to press, medicine is unsure of the final outcome in this controversial piece of legislation. The Senate version created concerns over lowering the Personal Injury Protection (PIP) coverage and requiring the use of nationally recognized "protocols and standards" for assessing proper treatment of automobile injuries. Yet, the Senate bill leans toward preserving the current \$250,000 mandatory PIP. The Assembly is considering a drastically lower PIP limit—one that would scarcely cover anyone involved in an accident much worse than a fender bender.

Prior to its budget recess, the Legislature considered several issues of interest to MSNJ mem-

bers. Should physician assistants or clinical nurse specialists/nurse practitioners be empowered to prescribe controlled dangerous substances? Separate bills have been discussed by the Senate Health Committee and meetings have taken place between interested parties.

Should insurance companies cover mental illness the same as physical illness? Require the same copays, same deductibles, and same coverage? Legislation that establishes mental health parity in health insurance has passed the Senate.

Should physicians be required to submit all health insurance claims, on behalf of their patients, and receive payment in just 30 days if submitted electronically? A move to bring health care into the next millennium (technologically speaking) has received "ayes" from the Senate Health Committee.

If patients have access to a myriad of computerized information, should a database of physicians—with information ranging from medical schools to malpractice experience—be available through the Internet? What information is public knowledge? Who would

maintain and update that information? What if incorrect information is included? A new bill, sponsored by the Senate minority leader Dick Codey (D-Essex), would require the state Board of Medical Examiners to computerize data.

Should patients have the right to hold HMOs liable for decisions deemed detrimental to their health and well being? Assemblyman Guy Talarico (R-Bergen) thinks so. He is sponsoring legislation that would make HMOs vulnerable to medical malpractice suits instituted by policyholders. The bill also would prohibit HMOs from requiring physicians to sign "hold harmless" clauses in their contracts—provisions that force physicians and their malpractice insurers to shield the HMOs from malpractice suits. There are two schools of thought about the bill in the physician community. One holds that it would occasion a glut of malpractice suits against HMOs—and thus, more suits against physicians as well, since a prudent plaintiff's attorney would have to include the physician in any suit against an insurer. The counter argument is that fewer

suits would result; the bill makes HMOs more responsible for the decisions to deny or to terminate payment for treatment, so they can be expected to make more responsible decisions.

The Senate Health Committee has released legislation that establishes specific criteria whereby patients could continue their treatment with a doctor who no longer is under contract with the patient's HMO. The bill would allow enrollees who are receiving life-saving care, postoperative followup care, oncological treatment, psychiatric treatment, or obstetrical care from a physician who was employed by or under contract with an HMO when the treatment was initiated, to continue to receive treatment from that physician for a period of up to one year after the doctor's contract with the network has expired. Health benefits would remain the same as when the doctor was under contract with the HMO. The bill's cosponsor, Senate Health Committee Chairman Senator Jack Sinagra (R-Middlesex) proudly explained, "This bill puts patients' needs first."

And Assemblyman John Kelly (R-Passaic), proud father of a physician, is promoting legislation that would make regular check-ups at the doctor's office part of any health insurance package in New Jersey. The bill would amend the "Health Wellness Promotion Act" of 1993 to require specific tests and screenings such as Pap smears, mammograms, cholesterol screenings, prostate examinations, and regular physicals be included in any health insurance policy sold in New Jersey.

One may think that the first four months of a two-year legislative session are quiet. Not so in the area of health care and medicine. Not so in the halls of the State House.

Senate President Donald DiFrancesco (R-Union) was the keynote speaker at the JEMPAC Forum during MSNJ's Annual Meeting in Atlantic City. Rumored to be among the candidates for Governor Whitman's job in 2001, DiFrancesco offered his thoughts, ideas, and insights into the future of health care from leadership's perspective.

Beverly Lynch

“THERE IS
NOTHING MORE
EXHILARATING THAN TO BE
SHOT AT WITHOUT
RESULT.”

—WINSTON CHURCHILL



Princeton Insurance Company policyholders are winning the battle against frivolous professional liability claims: 95% of company-managed cases are resolved in our insureds' favor. A successful defense means an unscathed professional reputation *and* preservation of financial security.

In today's legal climate, even the best doctors must dodge a bullet now and then. To marshal the heavy artillery on *your* side, consult one of the independent agents who represent Princeton or call us at 1-800-433-0157.



Princeton Insurance Company

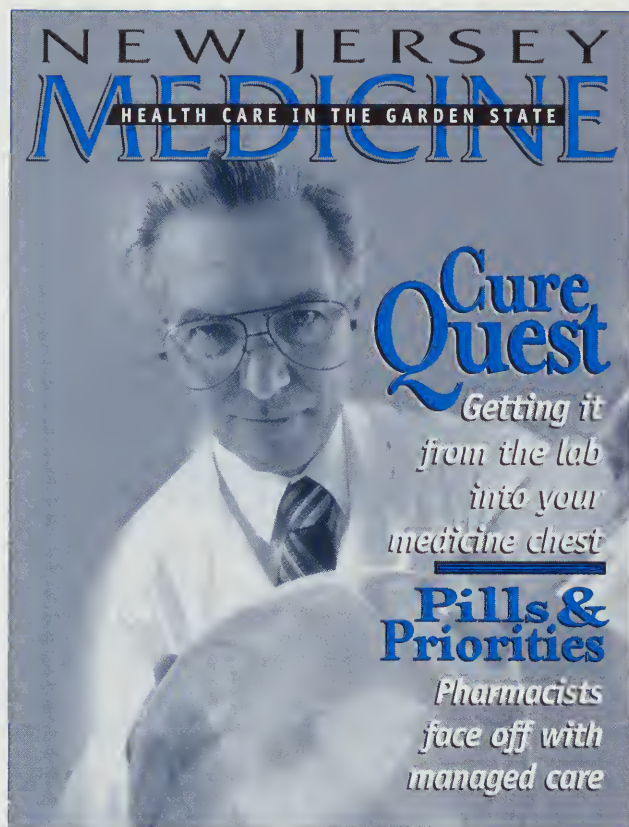
Professional Liability

Office Package Policy

Workers Compensation

Rated A- (Excellent) by A.M. Best Company 746 Alexander Road • Princeton, New Jersey 08540

JUST RIGHT. ♦



A new way of looking at
health care in the Garden State,
designed by people with a new way of
looking at your communications challenges.
Call, and we'll get it just right for you.



THREE BEARS

ADVERTISING • MARKETING COMMUNICATIONS

20 NASSAU STREET, PRINCETON, NJ 08542
609-688-1400

NEW JERSEY MEDICINE

MAY 1998

Editor-in-Chief **Howard D. Slobodien, MD**
Executive Editor **Geraldine R. Hutner, MA**
Assistant Editor **Nancy M. Propsner, BA**
Editorial Assistant **Karen Cuozzo, BS**
Advertising **Cookson Media Services**
Production **Trenttypo, Inc.**
Graphic Design **Three Bears Communications**
Cover Photo **Conrad Gloos**

President and Choir **R. Gregory Sachs, MD**
President-Elect **Irving P. Ratner, MD**
First Vice-President **Walter J. Kahn, MD**
Second Vice-President **Angelo S. Agro, MD**
Secretary **Bessie M. Sullivan, MD**
Treasurer **Eileen M. Moynihan, MD**
Immediate Post-President **Carl Restivo, Jr, MD**

BOARD OF TRUSTEES

S. Manzoor Abidi, MD
Stevan Adler, MD
Angelo S. Agro, MD
Churchill L. Blakey, MD
Donald J. Cinotti, MD
Rajendra Prasad Gupta, MD
David A. Ingis, MD
Philip J. Jasper, MD
Elliot M. Kraus, MD
Giovanni Lima, MD
Mark T. Olesnick, MD
Robert S. Rigolosi, MD
Michael J. Spedick, MD
John W. Spurlock, MD
J. Jerome Cohen, MD, OMSS
Carlo Porcaro, MD, IMG Section
Andrew Kunish, MD, Speaker of the House
Valerie Claps, MSNJ Alliance
Jamsheed K. Najmi, MD, Medical Specialty Societies

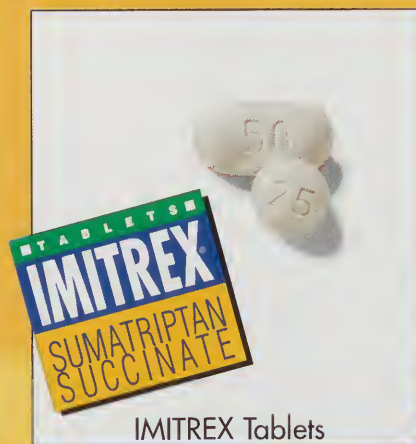
REVIEW BOARD

Sofia Anthony, MD, Paul W. Armstrong, Esq.,
Richard M. Ball, MD, Stanley S. Bergen, Jr, MD,
Harry M. Carnes, MD, Gary S. Carter,
Elizabeth G. Christopherson, Ellen M. Cosgrove, MD,
The Honorable Len Fishman, Joseph E. Gonzalez, Jr,
Paul J. Hirsch, MD, Ismail Kazem, MD,
Louis L. Keeler, MD, Carol J. Kientz, RN,
James R. Knickman, PhD, Paul R. Langevin, Jr,
George R. Laufenberg, Martin S. Levine, DO,
Henry R. Liss, MD, Gregg Lubinsky, RPh,
Ruth B. Mandel, Michael R. McGarvey, MD,
Julane Miller, Charles M. Moss, MD,
Patricia Murphy, PhD, RN, Tom O'Neill,
Fred M. Palace, MD, Mary Todd, DO,
William H. Tremayne, F. Kevin Tylus,
The Honorable Charlotte Vandervalk,
Joan Verplanck, Paul E. Wallner, DO

OUR COMMITMENT TAKES MANY FORMS



IMITREX Nasal Spray



IMITREX Tablets



IMITREX STATdose SYSTEM®

GlaxoWellcome

Glaxo Wellcome Inc.
Research Triangle Park, NC 27709
Website: www.glaxowellcome.com

30

Focus on health care

New Jersey leads the nation's quest for cures

As the medicine chest of the nation, New Jersey is in the forefront of groundbreaking approaches to disease. New Jersey laboratories continue this pace of progress.

35

In the spotlight

How is your company making New Jersey better?

What do the top pharmaceutical company chief executives have to say about what their firms have done for New Jersey? They each have an answer to this question.

43

Special feature

Public & private health care partnerships

Pharmaceutical and medical device companies are teaming up with providers, academic health centers, and physicians to ensure the best health care in the nation.

49

Current trends

Six unsung heroes

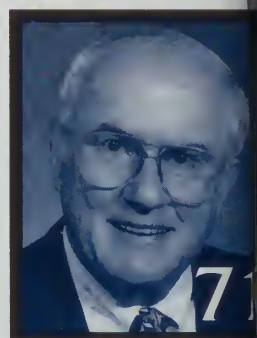
They work behind the scenes. They quietly pursue important developments for the health care profession. Their stories are priceless.



Governor Whitman honors
Raxanne Black.



Barbara Grill and Barbara
Changa, two unsung heroes.



William Tremayne, president,
HealthCare Institute of New Jersey.

PUTTING THE POWER OF
advanced medicine
INTO YOUR
hands



Parke-Davis, Division of Warner-Lambert...

a company dedicated to turning innovative

ideas into available new treatment options

as rapidly and efficiently as possible.



Division of Warner-Lambert Company
Morris Plains, New Jersey 07950

55 Clinical report

Managing HIV/AIDS patients

Advances in AIDS research and the medical management of HIV/AIDS prompt a reassessment and revision of guidelines for the management of HIV/AIDS patients in New Jersey.

63 Public health advances

Re-learning the way we learn

The efficiency squeeze in health care delivery is profoundly altering the way physicians and other health care professionals practice medicine. Pharmaceutical and medical device companies are responding.

67 Commentary

Dispensing the cure from the pharmacy

Take a look at the other side of the counter and hear the story of the impact of managed care from the pharmacist's point of view. How will pharmacists enhance managed care?

71 Financial matters

Dollars and sense of the health care industry

Put health and economics together, and most people think about the cost of health care, but there's another story—the surprising multiplier effect.



Gloria Ford and Vince Mattaliano review Roche's medication education program materials.

DEPARTMENTS

1 Newswatch

Issues abound in the New Jersey state Legislature. Here's what's going on.

12 Mail Stop

One medical group comments on its foray into managed care and inoffice HIV testing.

16 F.Y.I.

MSNJ celebrates service; new success for stroke victims; malpractice coverage.

21 Editor's Notes

Focus attention on the past, present, and future of the pharmaceutical and medical device industry.

25 Online @ MSNJ

You can travel from our favorite bookmarks of the month to the data doctor.

84 Calendar

Current listing of medical meetings around the state during the summer and fall.

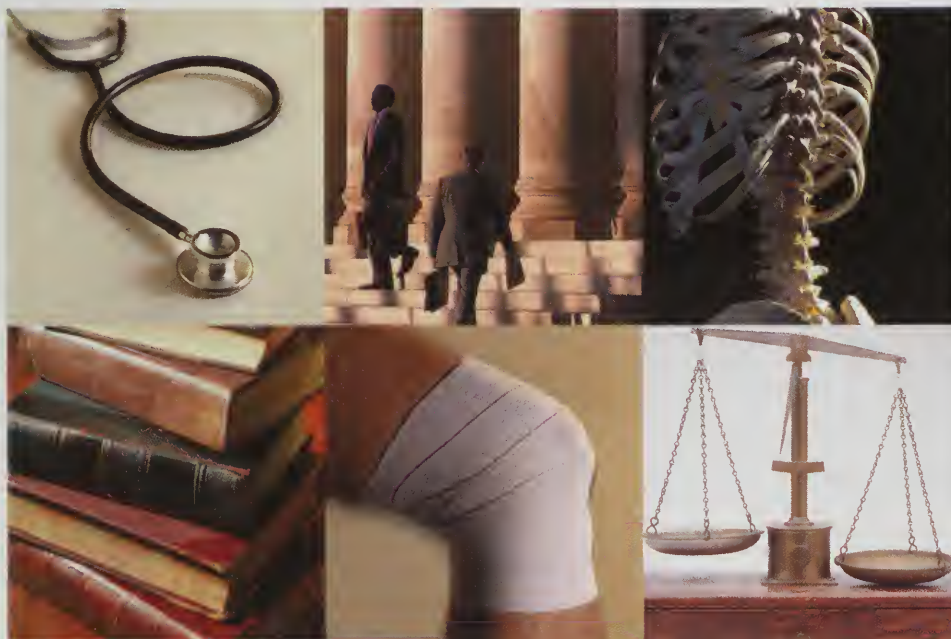
86 An Inside View

A look at the people behind the HealthCare Institute of New Jersey.

92 Photo Finish

We stopped the clock to check on the work of Dr. Joseph Takahashi, from Bristol-Myers Squibb.

Critical Treatment for the Future of Your Practice...



Before It's Too Late

Wilentz, Goldman & Spitzer's Health Care Law Practice Group serves health care professionals regarding: group practice formation and operations; management service organizations (MSOs); physician practice management companies (PPMCs); managed care contracting; physician-hospital organizations (PHOs); independent physician associations (IPAs); restrictive covenants; and regulatory, employment, tax and litigation matters. **Think of us as preventive medicine for your practice.**

For information please call our Health Care Law Practice Group Co-Chairs: Michael F. Schaff at (732) 855-6047 or Francis V. Bonello at (732) 389-5636.

**WILENTZ
GOLDMAN
& SPITZER**
ATTORNEYS AT LAW

**"Helping The Health
Care Professional"**

Woodbridge, NJ
New York, NY
Eatontown, NJ

<http://www.newjerseylaw.com>





Touch their Todays

Touch their Tomorrows

For more than a century we've been especially committed to the littlest of people. But our commitment only begins with babies. We dedicate our research and development, our innovative products to come, and our community endeavors to all members of the family, whatever their age.

Johnson & Johnson

Managed care physicians

Having been an employed shareholder of the Garden State Medical Group for 11.5 years, I found Dr. Slobodien's editorial in the October issue and the response by Ms. Wicks in the January issue to be quite fascinating.

It was interesting to read an acknowledgment, in the official magazine of the Medical Society of New Jersey (MSNJ), that my medical group was successful in providing good medical care at lower prices. During much of our history, employed managed care physicians such as myself were regarded as "black sheep" by the medical establishment. This was reflected by the lack of support given by MSNJ during our dispute with HIP.

This was, unfortunate, because the actual practice of medicine by the physicians within our medical group varied little from the rest of the medical community. Our financial success in the early 1980s and 1990s was principally due to prepayment, by directing volume to discounted specialists, hospitals, and ancillary services, and by the identification and aggressive collection of coordination of benefits. Individual physician decisions were almost never questioned.

That began to change with the growth of commercial for-profit managed care in New Jersey. The

group model suffers from an inherent lack of choice and the ability of the network model to purchase discounted services on the margin. With these changing economics, a larger patient base was needed to support the high-quality delivery system the Medical Group had built for HIP. Medical Group leadership had to either find new sources of patients (through additional HMO contracts) or downsize dramatically, reduce services, or lay off colleagues, and begin a death spiral of declining patient satisfaction.

The irony is that Pinnacle plans to open its health centers to multiple carriers in risk arrangements. This is exactly what the Garden State Medical Group was asking for when HIP refused to negotiate with us. The issue was not exclusivity, as HIP had argued, but access to capital. HIP needed it, PHP had it, and GSMG did not.

Your analysis of HIP's association with PHP is accurate. Honest, dedicated, and skilled caregivers, both physicians and nonphysicians, are

facing the reality of commercial interests' desire to improve the short-term bottom line. Huge turnover in physician and non-physician staff has occurred in the clinics that made up 80 percent of HIP's membership, since fall 1996. This turnover is carefully hidden in statistics that include physicians in a network that cares for a minority of HIP membership. Many patients lost access to their long-standing physicians, as well as other caregivers at the clinics.

Wicks is technically accurate when it was pointed out that HIP will not be acquired by PHP Healthcare. It did, however, sell the cooperative enterprise of insurer and delivery system that had made it unique in the market, delivered the high quality of care mentioned, and was responsible for the ranking in the *U.S. News and World Report*; a ranking methodology that favored staff model health plans.

I appreciate your support. We all have seen the results of this battle. The dismantling of a successful high-quality delivery system, loss of employment for dedicated health care workers, and patients forced to make difficult choices they should never have had to make. I hope that we all have learned from this experience and will no longer allow ourselves to remain divided within the profession.

Nicholas Bonvicino, MD

Requirements for letters

To submit a letter, fax (609.896.1368), e-mail (info@MSNJ.org), or mail your letter to New Jersey Medicine, Two Princess Road, Lawrenceville NJ 08648. Letters should be typed and double-spaced and should be no longer than 400 words with 4 references, if necessary. Include your full name, affiliation, address, and telephone number.

Letters are published at the discretion of the editor-in-chief and are subject to editing and abridgment. Letters may be published on MSNJ's web site, <http://www.msnj.org>. Financial associations or other possible conflicts of interest must be disclosed. Letters represent the opinions of the authors.



BASF Pharma

Committed to
Healthcare Professionals
and Patients for
More Than 85 Years

Providing Solutions
for the Treatment of:

**ENDOCRINE AND
METABOLIC DISORDERS**

PAIN

CARDIOVASCULAR DISEASE

WOUNDS

Inoffice HIV testing

Why are some family practice physicians no longer conducting HIV/AIDS tests in their office?

I recently had my annual examination with a New Jersey family practice that I have long regarded as progressive. As a patient for more than five years, I have always received superb care, especially during a particularly turbulent period of my life when I faced some drastic medical circumstances. In short, my physician "walks his talk" about setting high standards of good medicine delivered by caring professionals.

I asked my physician's guidance about the medical wisdom of seeking HIV screening. My physician noted that it is a good idea but said HIV screenings were not done in the office. I was told by a nurse that the reason was for my own legal protection. When I asked about information on HIV testing, I was told, "Just go to any clinic." How do I find out about such clinics? "Call any hospital."

I was puzzled. My blood was drawn for many different routine tests in my physician's office. My Pap test and any requests for sexually transmitted disease screening are honored without hesitation.

I did find out that there are several family practices that do offer HIV

testing in the office. Most emergency care centers will do an HIV screening.

So what's the big deal about HIV screening?

An association for family physicians suggested that some physicians shy away from doing HIV screening in their office because "insurance companies have been known to cancel policies for individuals—regardless of the results of the testing (positive or negative)." It appears that a person can be labeled as being at-risk for HIV/AIDS by simply requesting HIV screening! Does that mean that a person is labeled as being at-risk for cancer by simply requesting a routine Pap test?

I personally oppose any public policy that mandates HIV screening as a requirement for marriage licenses. Why are some family physicians making it easier for such proponents of this type of legislation (such as bill A-709) by shunning

requests for HIV screening by their patients?

Could it be true that insurance companies have been known to cancel life insurance policies, not health insurance policies, of people who knowingly apply for life insurance without revealing their HIV/AIDS status?

I would like to see some intelligent discussion about the logic behind physicians choosing whether or not to include HIV testing in their repertoire before anecdotes such as mine are used to demonstrate a need for universal HIV screening.

Let's make it easier, not more difficult, for people to discuss such topics as HIV/AIDS testing with the physician they trust in the privacy of a familiar office, rather than send them out the door with the impression that such a request should be kept in the closet.

Vivian Fransen

Average physician fees

Commenting on Neil E. Weisfeld's Newswatch section in the March issue of *New Jersey Medicine*, the numbers for mean and median fees for an office visit are meaningless! With more than 38 percent of care covered by managed care contracts, we can charge what we want, but take what we get.

Sheldon S. Schoen, MD

Requirements for letters

To submit a letter, fax (609.896.1368), e-mail (info@MSNJ.org), or mail your letter to *New Jersey Medicine*, Two Princess Road, Lawrenceville NJ 08648. Letters should be typed and double-spaced and should be no longer than 400 words with 4 references, if necessary. Include your full name, affiliation, address, and telephone number.

Letters are published at the discretion of the editor-in-chief and are subject to editing and abridgment. Letters may be published on MSNJ's web site, <http://www.msnj.org>. Financial associations or other possible conflicts of interest must be disclosed. Letters represent the opinions of the authors.



"I have a very select practice."

DR. ARTHUR WILLIAMS, DIRECTOR OF HEALTH SERVICES
SOUTHSIDE HEALTHCARE, INC., ATLANTA, GA

Dr. Williams doesn't see just anyone.
Only those who need him most.

As director of health services at Southside Healthcare, one of the nation's five largest community health centers, Dr. Williams oversees a team of health care professionals that managed 153,000 patient visits last year.

Dr. Williams' career reflects his commitment. He worked as a pharmacist, then went back to school and earned his MD. He paid for medical school by committing to work three years at a community health center — Southside. Nine years later, he's still there, still giving.

The Sharing the Care program donates Pfizer's full line of single-source pharmaceuticals to medically uninsured, low-income patients of federally qualified centers like Southside, in support of those who, like Dr. Williams, are part of the cure.

Sharing the Care: A Pharmaceuticals Access Program is a joint effort of the National Governors' Association, the National Association of Community Health Centers and Pfizer.



We're part of the cure.

CELEBRATION OF SERVICE

MSNJ member George J. Hill, MD, has been elected a national honorary life member of the American Cancer Society (ACS). He's been affiliated with ACS since 1968, serving as president, West Virginia Division (1980-1981) and of the New Jersey Division (1987-1989); national director-at-large (1989-1993); and professor of clinical oncology, 1989-1992. In 1985,



George J. Hill, MD

Hill was awarded the ACS Physician of the Year. At MSNJ, Hill was secretary, chair of the Committee on Credentials and of the Committee on Cancer Control, a delegate at the Annual Meeting, a *New Jersey Medicine* Review Board member, and a consultant to the Council on Public Health.

THE GOOD DOCTOR

MSNJ member Gary R. Brickner, MD, was named to the New Jersey state Board of Medical Examiners (BME) Executive Committee. Brickner has been a member of BME since his appointment by the governor in 1996. An obstetrician/gynecologist, Brickner is director and



Gary R. Brickner, MD

chair of the Department of Obstetrics-Gynecology at Robert Wood University Hospital at Hamilton. He also serves as director of the Robert Wood Johnson Obstetrics-Gynecology Group at Hamilton. His membership affiliations include the Mercer County Medical Society and the AMA. Brickner also was honored with the 1998 "Good Guy" award by the Women's Political Caucus of New Jersey.

STROKE VICTIMS SUCCESS

Bayshore Community Hospital has a new procedure that offers hope

for many stroke patients by reversing the impact of stroke. "We now have the



Dr. Schlesinger at Bayshore Community Hospital.

ability to reverse a stroke caused by a blood clot if we get to the patient in time," says MSNJ member Scott Schlesinger, MD, neuro-interventional radiologist at Bayshore—one of a handful of interventional radiologists in the state who have performed the procedure. "This represents a significant advance over all other previous therapies." The new procedure, intra-arterial thrombolysis, helps to restore patients to their pre-stroke condition. Patients with hemorrhagic stroke are not candidates for the procedure.

ARGUING FOR DNR

Health law counsel Leonard Nelson prevailed in front of the state Board of Medical Examiners last month concerning do-not-resuscitate (DNR) orders. Nelson, from the AMA, argued successfully for MSNJ members and the patients of New Jersey on behalf of DNR orders.



Leonard Nelson

HISTORY FOR THE FUTURE

Historical records from the Burlington County Medical Society (1829-1980) and the Essex County Medical Society (1816-1982) have been donated to the UMDNJ-George F. Smith Library of the Health Science's New Jersey History Manuscript Collections. The Library houses the largest collection of medical and health care historical data in the state.

MSNJ SWEEPS AWARDS

MSNJ is synonymous with promoting high-quality health care in the Garden State. It comes as no surprise that all the recipients of The Academy of Medicine of New Jersey 1998 awards are affiliated with MSNJ.



David I. Canavan, MD

MSNJ member David I. Canavan, MD, the founding medical director of the MSNJ Physicians' Health Program (PHP), was awarded the Edward J. Ill Award.

Regina Carlson was given the Citizen's Award. Carlson is the co-founder and executive director of New Jersey Group Against Smoking Pollution. She also provides her expertise as a member of the MSNJ New Jersey Breathes Coalition.



Regina Carlson

The President's Medical Educator's Award was given to MSNJ member Stanley S. Bergen, Jr, MD, the first president of UMDNJ. Bergen also is a member of MSNJ *New Jersey Medicine* Review Board.

The Medical Executive Award was presented to Arthur Ellenberger, the executive director of the Essex County Medical Society, MSNJ's component county society.

HOECHST MARION ROUSSEL

OUR COMMITMENT TO HEALTH CARE BEYOND MEDICINE TO HEALTH™



Making a difference in patients' lives will take more than new drug discoveries in the years ahead. It will mean going beyond what's written on a prescription pad. It must mean doing things that will help patients improve their health that medicine alone cannot. It will mean going Beyond Medicine to Health™.

Located in Bridgewater, New Jersey

Hoechst Marion Roussel

The Pharmaceutical Company of Hoechst
Kansas City, MO 64134

Hoechst ■

Provider of

allegra[®]
fexofenadine HCl 60 mg

allegra-D[™]
fexofenadine HCl 60 mg / pseudoephedrine HCl 120 mg
extended-release tablets

Amaryl[®]
glimepiride TABLETS

Anzemet[®]
dolasetron mesylate injection/tablets

CARAFATE[®]
1 gram / 10 mL (sucralfate)
SUSPENSION

CARDIZEM[®] CD
(diltiazem HCl)

CARDIZEM[®] Injectable
(diltiazem HCl injection)

CARDIZEM[®]
(diltiazem HCl)
Lyo-Ject[®]
25 mg (5 mg/mL)

CLAFORAN[®]
(cefotaxime sodium)

Nilandron[®]
(nilutamide)

Trental[®]
(pentoxifylline)
400 mg Tablets

MALPRACTICE COVERAGE

Governor Whitman signed legislation that requires that any physician or podiatrist who maintains a medical practice in New Jersey, and has responsibility for patient care, be covered by medical malpractice liability insurance. If that coverage is not available, the physician or podiatrist will be required to obtain a letter of credit, in an amount to be established by the state Board of Medical Examiners (BME).

Although the statute took effect on March 17, 1998, it requires BME to develop implementing regulations establishing the minimum amount of the letter of credit. Regulations also will seek to clarify the circumstances in which a licensee will be deemed to be maintaining a practice and/or having responsibility for patient care. Once those regulations are adopted, licensees will be notified by direct mail of the specific requirements.

NURSING EXCELLENCE

The Magnet Nursing Services Recognition Program, which recognizes nursing excellence, has added St. Peter's Medical Center as its newest Magnet Hospital. St. Peter's joins three other New Jersey hospitals—Hackensack University Medical Center, Robert Wood Johnson University Hospital, and Jersey Shore Medical Center—that have been designated as Magnet Hospitals. Only ten hospitals nationwide have earned this status. The Recognition Program is administered by the American Nurses Credentialing Center.

CALL OF DUTY

Brian A. Davis, MD, was one of 40 residents from around the nation honored with the AMA/Glaxo Wellcome Leadership Award. The



Brian A. Davis, MD (right)

award honors resident physicians with leadership commitment to community health through volunteer service. Davis is a physical medicine and rehabilitation fellow at UMDNJ in Newark and provides pre-participation medical screenings and medical coverage for various sporting events.

POWERFUL PRESCRIPTION

There are more smoking cessation aids available now than ever before. A physician's advice is the most motivating factor influencing a smoker's decision to quit. Yet only one-third of the smokers who visited their doctors last year were counseled to quit. MSNJ's New Jersey Breathes has designed a unique card for MSNJ members for use in their office. The laminated card lists smoking cessation products and therapies and how to help patients quit smoking. To obtain a free card, MSNJ members may contact Lisa Hibbs at New Jersey Breathes (609.896.1766, extension 258) or ldowns@ix.netcom.com.



"Someone gave me a terrible cold.
You can have it back."

New Jersey Medicine (ISSN-088-5842-X) is published monthly (since 1904) under the direction of the Council on Communications by the Medical Society of New Jersey (MSNJ), Two Princess Road, Lawrenceville, NJ 08648. Printed in Lancaster, PA, by Lancaster Press. Printed in USA. Whole number of issues 1127. Member's subscription (\$10) is included in MSNJ dues. Rates for nonmembers are \$50; outside USA, add \$20. Single copy is \$7.50. Periodicals postage paid at Trenton, NJ, and Lancaster, PA. Copyright 1998 by MSNJ. May 1998. Internet address: <http://www.msnj.org>. E-mail address: info@msnj.org. 609.896.1766. FAX 609.896.1368. Postmaster: Send address changes to *New Jersey Medicine*, Two Princess Road, Lawrenceville, NJ 08648. The appearance of advertising *New Jersey Medicine* is not a MSNJ guarantee or endorsement of the product or service, by the advertiser. When MSNJ has endorsed a product or program, that will be expressly noted.

Living Proof

that medical breakthroughs bring
miraculous recoveries



Rita was on the national waiting list for seven months. "Before my transplant in 1993, I had a hard time walking across the room. Now I hold a full-time job, help my husband with his business, and look forward to walking my dog every evening. And, another miracle - just a few months ago we had a baby. Life is full...again. I have so many people to thank, and so much to look forward to."

Rita Pearson got her life back, because someone cared enough to donate a kidney and an innovative treatment was available to prevent her body from rejecting the transplant.

After surgery Rita received a Roche drug that prevents rejection following kidney transplants. Roche has become an industry leader in transplant medicine and is researching new therapies that could lead to further advances in this critically important field. We're also working to heighten public awareness of the urgent need for organ donations so that more people can experience recoveries like Rita's.

Our products. Our people. Making a world of difference.



“High morale and outstanding performance emphatically go together.”

Fortune® magazine - January 12, 1998

1998 was the 16th year *Fortune* magazine published its article on “America’s Most Admired Companies.” This annual survey of external corporate reputations reflects how the business community perceives companies. Fifteen times, Merck placed in the top 10.

1998 also was the first year *Fortune* magazine published its article on “The 100 Best Companies to Work for in America.” This annual survey of internal corporate reputations is based on how employees perceive their own companies. Merck placed in the top 10.



A research-intensive pharmaceutical company.

The modern pharmaco- poeia is ours

As an undergraduate at Rutgers College, I spent many happy hours getting to know New Brunswick. Today, my wife and I spend many happy hours enjoying the culinary and cultural aspects of Johnson City, a New Brunswick reborn with the efforts of pharmaceutical giant Johnson & Johnson (J&J).

J & J is only one of the many drug manufacturers whose presence in the Garden State has made us the national center of that activity and who helped form the *HealthCare Institute of New Jersey (HINJ)*. This special issue of *New Jersey Medicine* is dedicated to them.

A December 1997 report delineated the impact these companies have on New Jersey. As William H. Tremayne said, "What automobiles are to Michigan and oil to Texas, the pharmaceutical and medical device industry is to New Jersey." The HINJ companies have over 53,000 New Jersey employees (of a total of more than 60,000), 115 statewide locations, a total 1996 payroll of \$3.2

billion, and an average professional salary of almost \$60,000. They spend 19 percent of revenue on research and development and have had 11,000 patents issued to them since 1985. Thirty-one percent of all FDA drug approvals since 1992 have gone to New Jersey companies, and, last year, 35 percent of the most significant of the new drugs originated here. In addition, as *The*

New York Times expressed on March 29, 1998, "A frenzy of high-tech research-facility construction is going on now in New Jersey, and more than 5,000 new scientific, management, and financial jobs are expected to be added in the coming years."

The articles in this special themed issue detail the effects of this industry on our economy. They also list many of the ways in which HINJ companies try to be good neighbors and community activists. They have participated in medical programs (asthma, nutrition, mental illness, arthritis, radiology, women's issues, epilepsy, orthopedics, and many others), have stimulated think tanks and discussion groups, have donated equipment and programs to schools, and have been philanthropic partners in local activities such as the United Way and the New Brunswick renaissance.

But pharmaceutical manufacturers also have their critics. Environmental groups continue to protest release of carcinogens and other toxic materials into dump sites. The FDA Modernization Act of 1997,

Howard D. Slobodien, MD



**Gout is not relieved
by a fine shoe
nor a hangnail by
a costly ring
nor migraine by a tiara.**

Plutarch, Moralia, c. AD 100.

Editor's Notes

which contains fast-track provisions, improved informational requirements, and other benefits, also is being criticized, in part, for allowing manufacturers to promote off-label usage; for letting medical devices be reviewed by private, not governmental, groups; for reducing the number of required clinical investigations; for lowering standards for reporting adverse events; for failing to provide sufficient regulatory power and funding to the FDA; and for superseding state consumer-oriented legislation.

The drug companies also must defuse criticism that they influence researchers by financial tie-ins. On February 2, 1998, the FDA issued regulations requiring physicians who test new drugs or devices to disclose financial arrangements with their suppliers. (Articles in *The New England Journal of Medicine* in January 1998 and in *The Journal of the American Medical Association* in April 1998 indicate that financial interests did affect physicians' views.) Ethicists, by and large, approved the new regulations, but felt that simple disclosure was, at best, a minimal necessity.

The carping noted is worthy of concerted industry effort—an effort I am sure will be pursued. But, I have other concerns:

- Drug manufacturers must intensify their efforts and ally more closely with the medical profession to combat resistance to antimicro-

**It is medicine,
not scenery, for which
a sick man must
go searching.**

Seneca, Letters to Lucilius, 1st C.

bials. Several New Jersey companies have intensified efforts to develop antibiotics with new mechanisms of action, with anticipated fast-track approval from the FDA. But HINJ also must advertise in the media and person-to-person the necessity for prudence in the use of these products: dosages, duration, and (especially) indications. We also should remember that New Brunswick's Louis Lasagna wrote in *Medical Tribune* in 1976 that many patients with a cold who felt sick enough to see a physician (a la Sam Levinson) probably had a complication needing antibiotics—a statement that provoked an unbelievable response from both sides. Maybe Robert Benchley had the best advice: "If you think you have caught a cold, call in a good doctor. Call in three good doctors and play bridge."

- HINJ must develop programs to identify adverse drug reactions and interactions in opportune fashion, despite the broader benchmarks granted them by the FDA.

The faster approval times also mandate increased care; in the past two years the FDA endorsed almost twice as many new drugs as heretofore. We certainly deserve timely information on drug interactions considered potentially "highly clinically significant" or "moderately clinically significant."

- HINJ should be a leader in helping physicians to understand the nuances of generic prescribing and of alternate sources of prescription-type medications. Why is there such a price differential between so many equivalent generics and brand names? Do generics in HMO formularies save money, or do they lead to increased costs? Is the FDA correct in ascribing equivalencies? How do we control the unregulated sales of drugs on the Internet? How can we assure a reasonable flow of safe, effective medications to poor and undeveloped countries?

I am confident HINJ and its confreres will rise to the occasion, as they did during the stellar effort of the United States pharmaceutical industry during World War II, when it carried the ball for a decimated war-torn Britain in producing enough penicillin for the Allied forces. For confirmation, look at downtown New Brunswick.

Howard D. Slobodien, MD

Editor-in-Chief

Help protect patients at risk of First MI

In asymptomatic patients age 45 and older...hypercholesterolemic...
with one or more additional cardiovascular risk factors

**Pravachol is proven to reduce
the risk of First MI by 31%***

**First
MI**

**First
MI**

**First
MI**

Pravachol is well tolerated. The most common adverse events are rash, fatigue, headache, and dizziness. Pravachol is contraindicated in the presence of active liver disease or unexplained persistent transaminase elevations, or for patients who are pregnant or nursing. • It is recommended that liver function tests be performed prior to and at 12 weeks following initiation of therapy or an elevation in dose. If a patient develops increased transaminase levels, or signs and symptoms of liver disease, more frequent monitoring may be required. • Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. Discontinue pravastatin if myopathy is diagnosed or suspected. • The combined use of pravastatin and fibrates should be avoided unless the benefit of further alterations in lipid levels is likely to outweigh the increased risk of this drug combination. In addition to diet, when diet and other nonpharmacological measures have been inadequate, in hypercholesterolemic patients without clinically evident coronary heart disease, Pravachol is indicated to reduce the risk of myocardial infarction; reduce the risk of undergoing myocardial revascularization procedures; reduce the risk of cardiovascular mortality with no increase in death from noncardiovascular causes.

It is not clear to what extent the findings of this study can be extrapolated to a similar population of women. Please see INDICATIONS AND USAGE, CONTRAINDICATIONS, WARNINGS (including Skeletal Muscle), PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information on the following page.

$p = 0.0001$

Reference: I. Shepherd J, Cobbe SM, Ford I, et al. Prevention of coronary heart disease with pravastatin in men with hypercholesterolemia. *Engl J Med.* 1995; 333:1301-1307.


PRAVACHOL[®]
pravastatin sodium 20 mg tablets

 **Bristol-Myers Squibb Company**

© 1998 Bristol-Myers Squibb Company, Princeton, NJ 08543

D3-K033C

Issued: February 1998

PRAVACHOL®

Pravastatin Sodium Tablets

CONTRAINDICATIONS: Hypersensitivity to any component of this medication. Active liver disease or unexplained, persistent elevations in liver function tests (see **WARNINGS**). *Pregnancy and lactation.* Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. **Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards.** If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus.

WARNINGS: **Liver Enzymes:** HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the US over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients. In the largest long-term placebo-controlled study with pravastatin (Pravastatin Primary Prevention Study; See **Clinical Pharmacology**), the overall incidence of AST or ALT elevations to greater than three times the upper limit of normal was 1.05% in the pravastatin group as compared to 0.75% in the placebo group. One (0.03%) pravastatin-treated patient and 2 (0.06%) placebo-treated patients were discontinued because of transaminase elevations. Of the patients with normal liver function at week 12, three of 2875 treated with pravastatin (0.10%) and one of the 2919 placebo patients (0.03%) had elevations of AST greater than three times the upper limit of normal on two consecutive measurements and/or discontinued due to elevations in transaminase levels during the 4.8 years (median treatment) of the study. **It is recommended that liver function tests be performed prior to and at 12 weeks following initiation of therapy or the elevation of dose.** Patients who develop increased transaminase levels or signs and symptoms of liver disease should be monitored with a second liver function evaluation to confirm the finding and be followed thereafter with frequent liver function tests until the abnormality(ies) return to normal. Should an increase in AST or ALT of three times the upper limit of normal or greater persist, withdrawal of pravastatin therapy is recommended. Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see **CONTRAINDICATIONS**). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see **CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism**). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect. **Skeletal Muscle:** Rare cases of rhabdomyolysis with acute renal failure secondary to myoglobinuria have been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see **ADVERSE REACTIONS**). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper normal limit, was rare (< 0.1%) in pravastatin clinical trials. Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected.** Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis, hypotension, major surgery, trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy. The risk of myopathy during treatment with another HMG-CoA reductase inhibitor is increased with concurrent therapy with either erythromycin, cyclosporine, niacin, or fibrates. However, neither myopathy nor significant increases in CPK levels have been observed in three reports involving a total of 100 post-transplant patients (24 renal and 76 cardiac) treated for up to two years concurrently with pravastatin 10-40 mg and cyclosporine. Some of these patients also received other concomitant immunosuppressive therapies. In one single-dose study, pravastatin levels were found to be increased in cardiac transplant patients receiving cyclosporine. Further, in clinical trials involving small numbers of patients who were treated concurrently with pravastatin and niacin, there were no reports of myopathy. Also, myopathy was not reported in a trial of combination pravastatin (40 mg/day) and gemfibrozil (1200 mg/day), although 4 of 75 patients on the combination showed marked CPK elevations versus one of 73 patients receiving placebo. There was a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy (see **PRECAUTIONS: Drug Interactions**). **The use of fibrates alone may occasionally be associated with myopathy.** The combined use of pravastatin and fibrates should be avoided unless the benefit of further alterations in lipid levels is likely to outweigh the increased risk of this drug combination.

PRECAUTIONS: **General:** Pravastatin may elevate creatinine phosphokinase and transaminase levels (see **ADVERSE REACTIONS**). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin. **Homozygous Familial Hypercholesterolemia:** Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors. **Renal Insufficiency:** A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3 α -hydroxy isomeric metabolite (SQ 31,946). A small increase was seen in mean AUC values and half-life ($t_{1/2}$) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored. **Information for Patients:** Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Drug Interactions:** **Immunosuppressive Drugs:** Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin. See **WARNINGS: Skeletal Muscle.** **Antipyrine:** Since concomitant administration of pravastatin had no effect on the clearance of antipyrine, interactions with other drugs metabolized via the same hepatic cytochrome isozymes are not expected. **Cholestyramine/Colestipol:** Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See **DOSEAGE AND ADMINISTRATION: Concomitant Therapy**). **Warfarin:** In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and C_{max} of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed. **Cimetidine:** The AUC_{0-12 hr} for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid. **Digoxin:** In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered. **Cyclosporine:** Some investigators have measured cyclosporine levels in patients on pravastatin, and to date, these results indicate no clinically meaningful elevations in cyclosporine levels. In one single-dose study, pravastatin levels were found to be increased in cardiac transplant patients receiving cyclosporine. **Gemfibrozil:** In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, C_{max}, and T_{max} for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended. In interaction studies with aspirin, antacids (1 hour prior to PRAVACHOL), cimetidine, nicotinic acid, or probucol, no statistically significant differences in bioavailability were seen when PRAVACHOL (pravastatin sodium) was administered. **Other Drugs:** During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to diuretics, antihypertensives, digitalis, ACE inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin. **Endocrine Function:** HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels, and as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p < 0.004$) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a $\geq 5\%$ rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones. **CNS Toxicity:** CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class. A chemically similar drug in this class produced optic nerve degeneration (Wallenian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear Wallenian-like degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180

mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg/day. **Carcinogenesis, Mutagenesis, Impairment of Fertility:** In a 2-year study in rats fed pravastatin at doses of 1, 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest (< 0.01). Although rats were given up to 125 times the human dose (H₀) on a mg/kg body weight basis, serum cholesterol levels were only 6 to 10 times higher than those measured in humans given 40 mg pravastatin as measured by oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times the human levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls (p < 0.05). The incidence was not dose-related and male mice were not affected. A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels of 0.3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) at 40 mg orally. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose male mice; maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye (Harderian gland) and gland of the eye (rodents) were significantly increased in high-dose mice than in controls. No evidence of mutagenicity was observed *in vitro*, with or without rat-liver S9 activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium*, *Escherichia coli*, a forward mutation assay in L5178Y TK +/– mouse lymphoma cells; a chromosomal aberration hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of genotoxicity in either a dominant lethal test in mice or a micronucleus test in mice. In a study in rats, with daily doses of 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 100 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with the reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular degeneration, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear. **Pregnancy: Pregnancy Category X.** See **CONTRAINDICATIONS.** Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/m²). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. There has been one report of severe congenital bone deformity, tracheo-esophageal fistula, and anasarca (water association) in a baby born to a woman who took another HMG-CoA reductase inhibitor with dextroamphetamine sulfate during the first trimester of pregnancy. PRAVACHOL (pravastatin sodium) should be administered to child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL (pravastatin sodium), it should be discontinued and the patient advised again as to the potential hazards to the fetus. **Nursing Mothers:** A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, nursing PRAVACHOL should not nurse (see **CONTRAINDICATIONS**). **Pediatric Use:** Safety and effectiveness in individuals under 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended.

ADVERSE REACTIONS: Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients. **Adverse Events:** All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom medical events were believed to be related or possibly related to the drug:

Body System/Event	All Events		Events Attributed to Study Drug	
	Pravastatin (N = 900) %	Placebo (N = 411) %	Pravastatin (N = 900) %	Placebo (N = 411) %
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhinitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

THROUGH THE MAZE

Sometimes the Internet seems limitless. CyberElerTM is the answer if you're looking for quality-filtered, online medical



CyberEler editor
Karen Clark

information for health care professionals. The bi-monthly newsletter does all the hard work and presents

a neat package of critiqued medical information off the Internet. More than just highlights from current web sites, *CyberEler* provides a profile section on a consumer medical topic and a journal news column with briefs from peer-reviewed medical online journals. For more information, contact *CyberEler* at 1.800.315.3082, FAX 303.604.1252.

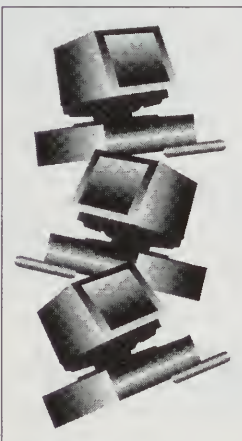
WORLD WIDE WEB TRAVELERS

Travelers seeking health conditions and vaccination recommendations for foreign countries and regions would telephone the Centers for Disease Control (CDC) for recorded announcements. Now, get that same

information off the web. Access the CDC web site (www.cdc.gov) and go to the "Travelers' Health" menu. You also can call toll-free 888.232.3299 to order a fax report. You still can get recorded voice announcements from the CDC (888.232.3228) by disease, not by geographic region.

DATA DOCTOR

Your computer just crashed. Lost data and hours of wasted time is all you have to show for your efforts. Not so, says Nikki Stange of Drive Savers (www.drivesavers.com), a data-recovery company. Drive Saves can



examine, assess, and restore damaged data on computer drives and disks and various media systems, as can On-

track Data International (www.ontrack.com). A suggestion from the experts: Back up your computer work faithfully.

BOOKMARKS

Pharmaceutical Research and Manufacturers Association
www.phrma.org

American Home Products Corp.
www.ahp.com

Becton Dickinson & Co.
www.bd.com

Bracco Diagnostics, Inc.
www.bracco.com

Bristol-Myers Squibb Co.
www.bms.com

C.R. Bard, Inc.
www.crbard.com

Hoechst Marion Roussel
www.hoechst.com

Hoffmann-La Roche, Inc.
www.roche.com

Johnson & Johnson
www.jnj.com

Merck & Co., Inc.
www.merck.com

Novartis Pharmaceuticals Corp.
www.novartis.com

Nycomed Amersham Imaging Americas
www.nycomed-amersham.com

Pfizer, Inc.
www.pfizer.com

Schering-Plough Corp.
www.sch-plough.com

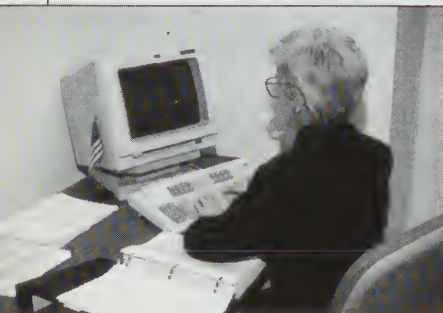
Warner-Lambert Co.
www.warner-lambert.com

THE ENGLISH EXPERTS

In a dilemma over grammar, syntax, or punctuation? Then go to the experts at The Grammar Doctor (w3.one.net/~sparks25/gdoctor.html); Grammar Queen (www.grammarqueen.com); or The Grammar Lady (www.grammarlady.com). You'll be on your way to perfect English!

JUNK E-MAIL

Nobody likes it, but everybody gets it. One solution to disarm the spammers is to track spam, suggests Michelle Slatalla of *The New York Times*.



The return address at the very top in the header of the message contains the domain names of the computer that sent the spam and the computer-specific Internet Protocol (IP) number. With the IP number, use Sam Spade (www.blighty.com/products/spade for Windows 95 and NT users; www.blighty.com/spam/

spade.html, a web version of Sam Spade) to find out who owns a domain name and the provider responsible for assigning a particu-



e - m a i l

lar IP number. Usually there will be an e-mail address where you can forward complaints. You also can do a "trace route" and generate a list of all the computers through which a piece of spam passed.

GET IT ONLINE

The U.S. Department of Commerce's National Technical Information Service (NTIS) offers the *Drug Enforcement Administration Controlled Substances Act Registration Information* online. With this subscription service, the user can verify credentials of practitioners at any time. This on-line service complements the CD-ROM and magnetic tape subscriptions that still are available. For more information, contact NTIS Subscriptions Department at 703.605.6060. ■

BOOKMARKS

ccc.silverplatter.com

Just for primary care physicians, PRIMARY is a biweekly web publication that keeps physicians up-to-date on clinical issues and concerns.

www.HealthAtoZ.com

A comprehensive search engine for all medical and health-related sites on the Internet.

www.umdj.edu/librweb

Get online with the University of Medicine and Dentistry of New Jersey's medical and health science libraries.

www.saintbarnabas.com

Check out the state's largest health care system's new web site, the Saint Barnabas Health Care System.

www.newshunt.com/

Turn to this site, NewsHunt, to find "searchable, reliable, and free new sources."

www.priceline.com

For the latest and least expensive airline seats, you have your choice at your fingertips.



AMERICAN HOME PRODUCTS CORPORATION

Focused on the Future

American Home Products Corporation is focused on finding breakthrough medical therapies in areas of critical need, with one of the largest commitments to basic and clinical research in the pharmaceutical industry. Millions of people benefit from our Company's broad expanding lines of prescription drugs, vaccines, nutritionals and over-the-counter medicines. We are also recognized for leadership in developing, manufacturing and marketing animal health and agricultural products. In 1997, AHP invested \$1.5 billion in research and development of which more than \$1.2 billion was invested in pharmaceutical and biotechnology research.





UNPRECEDENTED ACCOUNTABILITY
CONFLICTING PERFORMANCE CRITERIA
MULTIPLE, FRAGMENTED PROCESSES
TIME-CONSUMING
MORE DOCUMENTATION
LESS PATIENT CARE
HIGH COST
DUPLICATIVE OFFICE-SITE REVIEWS
INCONSISTENT CREDENTIALING
NEVER-ENDING PAPERWORK
ADMINISTRATIVE HASSLES

Our solution has arrived.

One Time

One Source

One Standard



American
Medical
Accreditation
Program

The new American Medical Accreditation Program (AMAP), physicians complete an application **ONE TIME**, have their credentials primary-source reviewed **ONE TIME**, and have an on-site office review **ONE TIME**.

AMAP then provides an Accreditation report and certificate to each physician who meets the AMAP national standard.

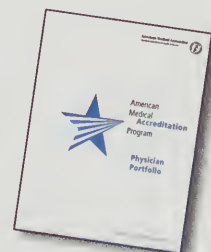
AMAP will provide a complete portfolio of verified credentials, office site information, and other frequently requested information to each health plan and employer that uses AMAP and with whom the physician is affiliated.

The American Medical Accreditation Program is a voluntary, comprehensive accreditation program that measures and evaluates individual physicians against national standards, criteria and peer performance in five areas: Credentials, Personal Qualifications, Environment of Care, Clinical Performance, and Patient Care Results.

Meeting and maintaining AMAP's high standard earns a physician AMAP Accreditation – a new national benchmark of physician quality.

AMAP, your one source for the new national standard of physician quality information, has arrived.

To learn more about the many benefits AMAP has to offer *your* organization, call the AMAP Resource Center at 1-888-881-AMAP (2627) or visit the AMAP Web site at <http://www.ama-assn.org>.



The standard in quality physician care.

American Medical Association
Physicians dedicated to the health of America



IT IS A RELENTLESS JOURNEY SPANNING MORE THAN 4,000 YEARS. AND, AS THE 21ST CENTURY NEARS, NOWHERE IS THE PURSUIT OF THE ORIGIN OF DISEASE MORE VISIBLE THAN WITHIN NEW JERSEY'S BORDERS. THE AIM IS TO HELP PREVENT, DIAGNOSE, AND TREAT DISEASE AROUND THE WORLD.

New Jersey leads the nation's quest for cures

In the last five years, New Jersey-based pharmaceutical companies have received almost one-third of all Food and Drug Administration (FDA) approvals for significant new drugs, earning the state the distinction as the "medicine chest of the nation." Last year, 17 of the 48 new molecular entities approved by the FDA came from New Jersey-based pharmaceutical companies. Those same companies investigated more than 700 compounds in 1996 and conducted clinical trials for almost 60 diseases.

"Not only are we making advances in pharmaceuticals, but we're developing better materials for medical

devices and improving our diagnostic capabilities—all aimed at helping prevent, diagnose, and treat disease," says Robert Gussin, corporate vice-president, science and technology, Johnson & Johnson.

Numerous companies are pumping more dollars into research pipelines. Johnson & Johnson, one of the top ten U.S. companies in terms of total research and development spending, devoted more than \$2.1 billion to research and development in 1997. Merck dedicated \$1.7 billion to research in 1997, an increase of 16 percent over 1996. Bristol-Myers Squibb will double the size of its dis-



ork at Bracco Research USA, Inc. is Thomas Katona, senior research investigator. Pharmaceuticals.

covery operation over the next five years. Hoechst Marion Roussel will add another 150 scientists to its newly opened research center in Bridgewater.

"As an industry, we're reinventing ourselves," says Kevan Clemens, vice-president, clinical operations, Hoffmann-La Roche. "Innovative therapies, new technology, and partnerships will keep us in the forefront."

In New Jersey companies, scientists are targeting cancer, cardiovascular disease, central nervous system disorders, dermatological disorders, diabetes, gastroenterological diseases, glaucoma, gynecological disorders, hematological disease, infectious disease, inflammation/autoimmune disease, liver disease, mobility disorders, obesity, pain, respiratory disorders, and transplant rejection. In addition, pharmaceutical companies have developed a host of new technological innovations that promise to accelerate the pace of progress. Genomics, monoclonal antibodies, and several other scientific breakthroughs have been around for a decade or so. But now, automation is bringing the fruits of these new approaches to the entire drug development process.

For example, automation and robotics are being used to learn more about important genes and the proteins they make, to create molecular models of compounds that look especially interesting and to simultaneously synthesize thousands of potential drugs that might act on a gene or its protein.

Also, there have been enormous strides in the development of new biocompatible materials, and bigger and better computers are bringing all of the information together for rapid analysis.

"It's an amazing list of advances," says Gussin. "In all of our lifetimes, science and technology have never been more exciting."

A sampling of innovations include:

- A new treatment for Parkinson's disease from Hoffmann-La Roche that helps patients better control their symptoms.

- Tissue glue for wound closure, as well as new approaches to tissue spectroscopy that may aid in the diagnosis of cervical cancer that is being studied at Ethicon.

- New products for depression, including a once-daily extended release capsule from Wyeth-Ayerst and a new product from Merck in phase II trials.

- The first platelet-derived growth treatment for wound healing in diabetic foot ulcers, developed by The R.W. Johnson Pharmaceutical Research Institute and marketed by Ortho-McNeil Pharmaceutical Company.

- Knoll Pharmaceutical Company's treatment in clinical trials for acute ischemic stroke, derived from the venom of the Malayan pit viper.

- Longer-lasting prostheses made of ceramics, currently under investigation by a Johnson & Johnson biomaterials group.

- Several new agents from Bracco Diagnostics, which improve results of ultrasound tests, are awaiting FDA approval. One is a contrast agent that rids the body of gas, which can distort scans; the other is an intravascular microbubble agent that blocks stray signals from deep within the body, improving ultrasound images used in the diagnosis of cardiovascular disease.

- There also are potential new gene-based therapies for cancer. Merck is working on a compound, now in animal studies, that may disarm a gene implicated in 20 to 30 percent of cancers, and Janssen Research Foundation is developing a therapy that may be more specific and less toxic than existing treatments.

Scott Berk, PhD, completing research at a Merck laboratory.



"The 'me, too' drugs of the '80s are gone," recalls Philippe Bey, head of drug innovation and U.S. approvals for Hoechst Marion Roussel. "We're focusing efforts on essential, not discretionary, medicines."

But research is a risky business. Only one in ten compounds actually makes it to market. Bringing a compound from the laboratory bench to the pharmacy shelf has traditionally taken up to 15 years

and costs up to \$500 million.

A streamlined regulatory process is helping shorten that timeline, possibly even cut it in half. The 1997 FDA Modernization

Act and the 1992 Prescription Drug User Fee Act (PDUFA) mean faster approvals for much-needed drugs and expanded access to therapies undergoing FDA review. Through PDUFA, pharmaceutical companies have provided \$360 million in user fees, enabling the FDA to hire 600 additional reviewers. Fees will reach more than one-half billion through the year 2002.

New scientific technologies also are fueling discovery in many New Jersey laboratories. Companies are building internal capabilities around genomics, combinatorial chemistry, high throughput screening, and bioinformatics.

Genomics, or the study of proteins made by specific genes, is combining with advances in automation, making it easier for scientists to identify the specific enzymes or receptors that malfunction or are missing in a disease. Schering-Plough, Merck, Janssen Research Foundation, Hoffmann-La Roche, Bristol-Myers Squibb, and American Home Products are among the companies that collaborate with leading genomics organizations to develop highly selective drugs with fewer side effects.

The R.W. Johnson Pharmaceutical Research Institute has developed its own so-called "DNA chip," which helps scientists determine if a DNA fragment is tissue specific. The chip also allows them to compare genes found in healthy tissue to those in tumors or to those treated with medications.

Another key technology is combinatorial chemistry, in which scientists take a compound that they know acts on a target molecule or receptor and, in an automated process, rapidly synthesizes hundreds of thousands of



A Hoechst Marion Roussel project team discusses new approaches to treating schizophrenia.

variations on that compound. At Hoechst Marion Roussel and other companies, automated robots enable biologists to screen large numbers of chemical compounds

simultaneously, which results in more selective and effective compounds with fewer side effects.

Bristol-Myers Squibb introduced combinatorial chemistry into its operation in 1995 and since then, "our output has increased by tenfold," notes William Koster, senior vice-president, Drug Discovery, Bristol-Myers Squibb. Koster says the company also is developing a virtual screening technique. The company has developed software that takes the structure of a protein, e.g. from an x-ray, and rapidly screens a million compounds against the structure without ever touching a test tube.

High-throughput screening is another technology fueling laboratory results. This computer-based technology enables researchers to use robots to test thousands of different compounds every day against a given protein implicated in a disease. Bristol-Myers Squibb is among the companies that will unveil new ultra high-throughput screening systems this year. The technology will sort more than 100,000 assays per day—a process that would previously have taken months—in search of promising compounds for development.

Bioinformatics also is making important contributions to research. "In its broadest sense, bioinformatics is the application of informatics and computer science technology to problems in biology," says Clemens. "We have an avalanche of data coming in from new methodologies, and bioinformatics helps us analyze and manage this data."

"Technology gives us the tools to explore and discover things we never have before," relates Magid Abou-Gharbia, vice-president, chemical sciences division, Wyeth-Ayerst. "Ultimately, this exploration will lead us to new opportunities to understand and treat disease—opportunities that will help us improve the health of those, not only in New Jersey, but around the world."

The Novartis Institute for Biomedical Research is proud to play a role in the New Jersey health care community.

Our 2,000 employees are leading the search for new approaches to medical care through state-of-the-art drug discovery and development as well as gene therapy, stem cell research and xenotransplantation.

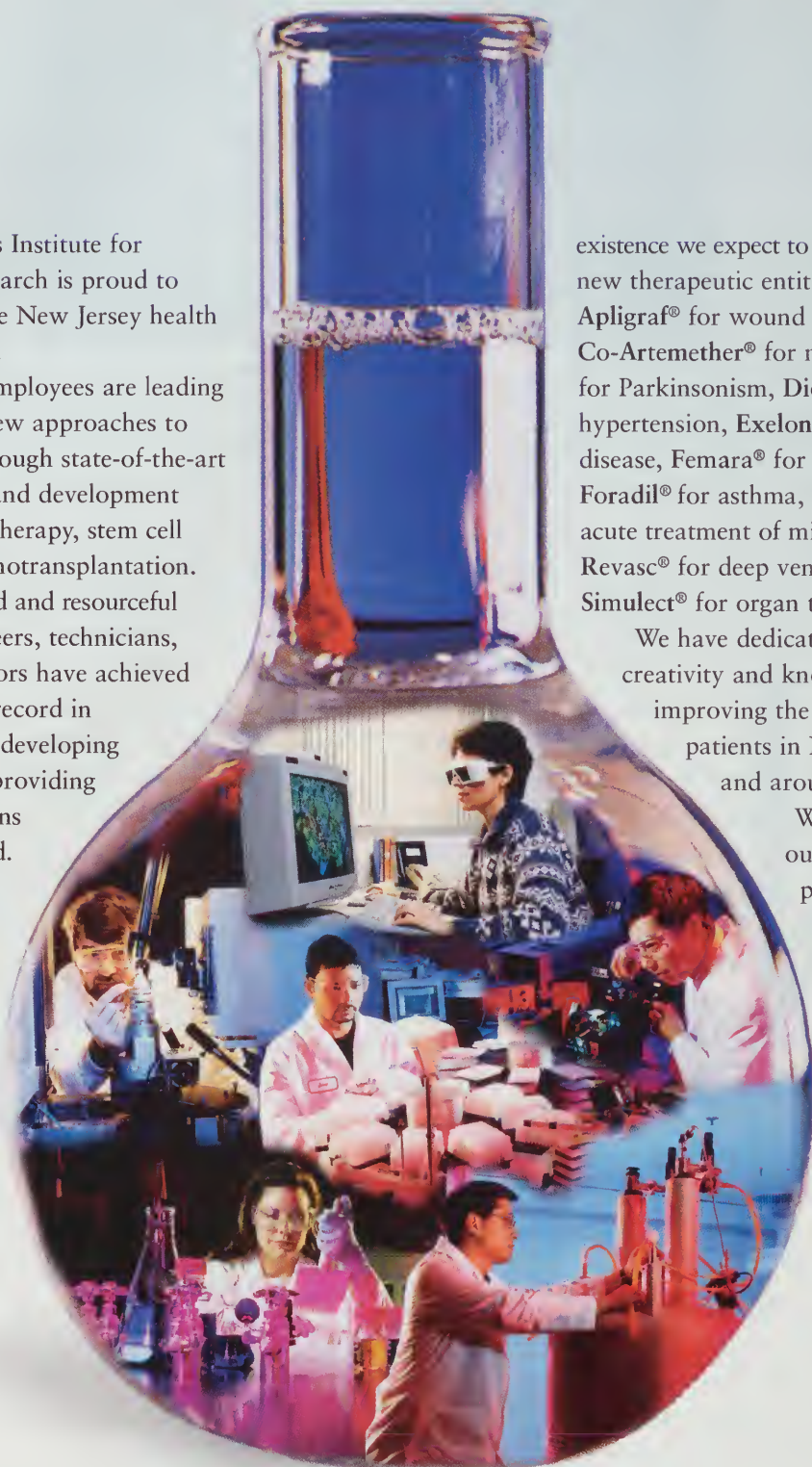
These talented and resourceful scientists, engineers, technicians, and administrators have achieved an outstanding record in discovering and developing new drugs and providing them to physicians around the world.

By the end of Novartis' first two years in

existence we expect to launch ten new therapeutic entities including: **Apligraf®** for wound healing, **Co-Artemether®** for malaria, **Comtan®** for Parkinsonism, **Diovan®** for hypertension, **Exelon®** for Alzheimer's disease, **Femara®** for breast cancer, **Foradil®** for asthma, **Migranal®** for acute treatment of migraine headache, **Revasc®** for deep venous thrombosis, **Simulect®** for organ transplantation.

We have dedicated our skill, creativity and knowledge to improving the health of patients in New Jersey and around the world.

We measure our success by the people we help.



**Novartis Institute for
Biomedical Research**

1 QUESTION

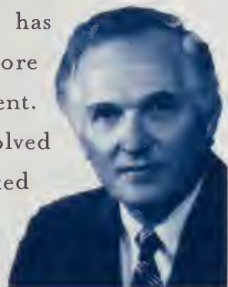
How is your
company making
New Jersey
better?

15 ANSWERS

NEW JERSEY MEDICINE ASKS THE CHIEF EXECUTIVE OFFICERS OF 15 LEADING PHARMACEUTICAL AND MEDICAL DEVICE FIRMS TO TELL US THE MOST GRATIFYING INITIATIVE THEIR COMPANIES HAVE TAKEN TO MAKE NEW JERSEY A BETTER PLACE TO LIVE. HERE'S WHAT THEY SAY.

PEOPLE ARE HELPING PEOPLE

American Home Products Corporation relocated to Madison in 1993. One of the first things we did was to get involved with the United Way of Morris County. Over the past four years, our employee gift has increased more than 200 percent. Getting involved with the United Way has encouraged our employees to become vol-



John R. Stafford

unteers in our community. The United Way is about people helping people and we're proud to provide financial, as well as volunteer,

support to this organization. John R. Stafford, chairman, president, and CEO, American Home Products Corporation

HEALTHY LIVES

In 1997, Becton Dickinson marked its 100th anniversary and renewed its commitment to help all people live healthy lives. We established a centennial fund to support health care needs around the world. The program has funded initiatives including the Henry P. Becton School of Nursing, the Hope for Kids immunization outreach program, and a UNICEF partnership to eradicate childhood tetanus. What makes our efforts special is that we combine financial support with product donations and volunteerism by our employees.

Clateo Cas-
tellini, chair-
man, presi-
dent, and
CEO, Becton
Dickinson

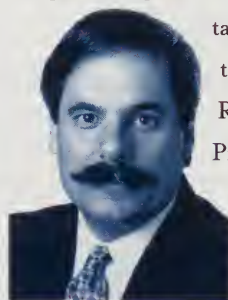


Clateo Castellini

HOME SWEET HOME

In addition to the products and services of Bracco Diagnostics Inc., we support local charitable efforts. In reality, though, the most gratifying initiative we've undertaken is staying in New Jersey despite corporate pressure to es-

tablish headquar-
ters in New York.
Remaining in
Princeton is a
better bus-
iness decision
and a better



John J. Cornille

result for our
people. John J. Cornille, presi-
dent and CEO, Bracco Diag-
nostics, Inc.

HANDS-ON SCIENCE



Charles A. Heimbold, Jr.

Bristol-Myers Squibb Company has a profound interest in enhancing science education to meet the needs of a society whose future is based on innovation and scientific advancement. Our community efforts in New Jersey include a regional elementary science reform program—in partnership with the National Academy of Sciences and the Smithsonian Institute—to encourage early enthusiasm for science through the use of hands-on and inquiry-based classroom experiments. The program provides science experiment kits for students, training for teachers on how to use these kits, and ongoing classroom support from our scientists. We are preparing today's young minds for tomorrow's opportunities. **Charles A. Heimbold, Jr., chairman and CEO, Bristol-Myers Squibb Company**

THEY ARE ON THE GO

Access to appropriate medical care often is a challenge for families with children who have special needs. This especially is true for inner-city families who must rely on public transportation. With a \$100,000 donation from **C.R. Bard, Inc., Children's Specialized Hospital** was able to purchase a **MOBILE Therapy Unit** and now provides services in a self-contained, independent setting in communities throughout New Jersey. **William H. Longfield, chairman and CEO, C.R. Bard, Inc.**



William H. Longfield

LEARNING SKILLS

Education is a priority for **Hoechst Marion Roussel** and we're excited about two recent initiatives. We're partnering with the **A+ for Kids Teacher Network** to support the development of innovative science and math programs in more than 2,200 New Jersey public schools. With the New Jersey

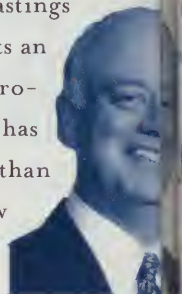


Richard J. Markham

Arthritis Association, we're sponsoring a continuing medical education program for non-rheumatologists, who are increasingly diagnosing and treating arthritis diseases. **Richard J. Markham, CEO, Hoechst Marion Roussel**

SMART TALK

Advances in science and technology have given us new possibilities, freedom, and ethical responsibilities. **Hoffmann-La Roche, Inc.** in partnership with the **New Jersey Science Supervisors Association** and the **Hastings Center**, supports an innovative program that has helped more than 32,000 New Jersey students discuss bio-ethical issues that affect their lives. Topics include genetics, HIV/AIDS, the role of animals in science, and the environment. **Patrick J. Zetterstrom, president and CEO, Hoffmann-La Roche, Inc.**



Patrick J. Zetterstrom

DAY OF CARING

While **Howmedica Worldwide** is a leading global innovator in orthopedic products, our location in New Jersey has given us several opportunities to reach out to



Jack O'Mahony

surrounding communities. For example, we encourage employees to contribute participation, well as money, to assist the United Way. As a result, 12 Howmedica employees volunteered in the United Way of Bergen County Day Caring, giving a full day at the construction site for the Habitat for Humanity Project in Paterson. Jack O'Mahony, president, Howmedica worldwide

LOCAL OUTREACH

One of our newest partnerships, New Brunswick: America's Health Care City," is an exciting outgrowth of Johnson & Johnson's



Robert N. Wilson

long-standing commitment to the city where our company began. Health Care City celebrates the unique convergence of research, treatment, and corporate health care expertise in New Brunswick, and it recognizes the

critical role of nonprofit organizations in our state. We are pleased to support Health Care City's National Headquarters Project, which is creating a centrally located office environment for health- or child-focused nonprofit groups designed to support growth, enhance collaborative opportunities, and nurture spirit. Robert N. Wilson, vice-chairman, Board of Directors, Johnson & Johnson

NO PLACE LIKE NOVA

I am proud to say that Knoll Pharmaceutical Company has made a commitment to the Epilepsy Foundation of



Carter H. Eckert

New Jersey's Camp Nova. Camp Nova provides a place where kids with epilepsy get their wish to be treated no differently than anyone else. Camp Nova is not about medical research or statistics. It's about what it means to live day-to-day with epilepsy. Carter H. Eckert, president, Knoll Pharmaceutical Company

TAKING THEM TO THE TOP

One of the most gratifying experiences is to see children's eyes light up with excitement and wonder when they learn something new.



Raymond V. Gilmartin

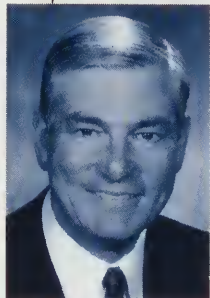
Merck & Company, Inc. is helping to ignite this spark in elementary and middle school students through the Merck Institute for Science Education. Established in 1992, the Merck Institute works closely with educators in Linden, Rahway, and Readington Township to improve science and math education. Our goal is to help teachers use inquiry-based science education to nurture children's natural enthusiasm and curiosity about science. Not only will this improve our children's education, it will help ensure a pool of qualified scientists for tomorrow. Raymond V. Gilmartin, chairman, president, and CEO, Merck & Company, Inc.

COMMUNITY PARTNERS

In April 1997, employees at Novartis Pharmaceuticals Cor-

In the Spotlight

poration launched a program of community outreach and volunteerism to commemorate the one-year anniversary of share-



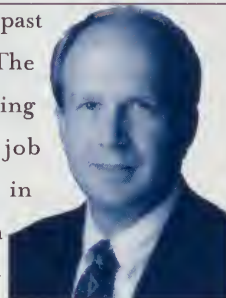
Wayne P. Yetter

holder approval of the Ciba-Sandoz merger. More than 400 Novartis employees cleaned, painted, tutored, sorted, and served food at area agencies. Many more donated items to on-site collection drives and hundreds more participated in site volunteer fairs to learn about volunteer opportunities. Community Partnership Day demonstrated Novartis' commitment to social responsibility; this underscored that our employees care and our company aspires to be an active corporate citizen and good neighbor. Wayne P. Yetter, president and CEO, Novartis Pharmaceuticals Corporation

BIG BYTES

Nycomed Amersham Imaging Americas has donated a significant number of computers and peripheral equipment, such as printers, to educational and health and human service nonprofit organizations throughout New

Jersey over the past several years. The equipment is being used for job training, classes in English as a second lan-



Daniel L. Peters

guage, and enhanced office recordkeeping and resource utilizations. At Nycomed Amersham, we believe in contributing to the well-being of the cultures, communities, and environments in which we live and work. Daniel L. Peters, president, Nycomed Amersham Imaging Americas

NEW STUDENT LABORATORIES

In 1997, Schering-Plough Corporation funded a \$350,000 renovation of science laboratories at the David Brearley Middle/High



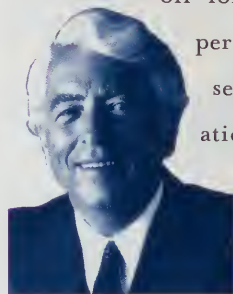
Richard Jay Kogan

School in the Kenilworth public school district. In addition to financial assistance, the corporation's engineers, researchers, and purchasing professionals lent their expertise to the project, which gave Brearley the

best-equipped public school laboratories in New Jersey. Richard Jay Kogan, president and CEO, Schering-Plough Corporation

VOLUNTEER ANGELS

Warner-Lambert Company's most gratifying initiative has been building a structure that strengthens the ability of our colleagues to perform community service. We facilitate coat and food drives, Christmas Angel programs, United Way Day of Caring, and Community Classic to provide



Melvin R. Goodes

off for colleagues to perform volunteer services. Community Classic Hands provide donations as much as \$500 to organizations with which colleagues are involved. We also support extensive educational partnerships with the community. Partnering with our colleagues enhances Warner-Lambert's ability to make New Jersey a better place in which to live. Melvin R. Goodes, CEO, Warner-Lambert Company

For patients suffering from
chronic idiopathic urticaria

the Performance of hydroxyzine ... *Without Sedation*

CLARITIN® delivers proven efficacy vs hydroxyzine¹

- The percent of CLARITIN® patients reporting marked or complete relief of urticaria symptoms was comparable to the percent of hydroxyzine patients, and greater than the percent of patients taking placebo

CLARITIN® delivers a proven nonsedating* safety profile

CLARITIN® offers 24-hour coverage and distinct patient benefits

- Nonsedating* CLARITIN® offers the convenience of q.d. dosing (vs t.i.d. dosing for hydroxyzine), acceptance on over 93% of formularies, and the proven track record of over 4 billion patient days worldwide

"Nothing but blue skies from now on"

In controlled clinical trials in seasonal allergic rhinitis patients using the recommended dose, the incidence of headache (12%), somnolence (8%), fatigue (4%), and dry mouth (3%) with CLARITIN® was similar to that of placebo (11%, 6%, 3%, and 2%, respectively).

The incidence of sedation with CLARITIN® (8%) was similar to that of placebo (6%) at the recommended dose.

In studies with CLARITIN® at doses 2 to 4 times higher than the recommended dose of 10 mg, a dose-related increase in the incidence of somnolence was observed.

Reference

1. Monroe EW, Bernstein DI, Fox RW, et al. Relative efficacy and safety of loratadine, hydroxyzine, and placebo in chronic idiopathic urticaria. *Arzneim.-Forsch./Drug Res.* 1992;42:1119-1121.

Once-a-day

Claritin®
10 mg (loratadine)
TABLETS

Please see next page for brief summary of Prescribing Information.

"BLUE SKIES" by Irving Berlin © 1927 (Renewed) by Irving Berlin. Irving Berlin Music Company.

CLARITIN®
brand of loratadine
TABLETS, SYRUP, and
RAPIDLY-DISINTEGRATING TABLETS

BRIEF SUMMARY (For full Prescribing Information, see package insert.)
INDICATIONS AND USAGE: CLARITIN is indicated for the relief of nasal and non-nasal symptoms of seasonal allergic rhinitis and for the treatment of chronic idiopathic urticaria in patients 6 years of age or older.

CONTRAINDICATIONS: CLARITIN is contraindicated in patients who are hypersensitive to this medication or to any of its ingredients.

PRECAUTIONS: General: Patients with liver impairment or renal insufficiency (GFR < 30 mL/min) should be given a lower initial dose (10 mg every other day). (See **CLINICAL PHARMACOLOGY: Special Populations**.)

Drug Interactions: Loratadine (10 mg once daily) has been coadministered with therapeutic doses of erythromycin, cimetidine, and ketoconazole in controlled clinical pharmacology studies in adult volunteers. Although increased plasma concentrations (AUC 0-24 hrs) of loratadine and/or descarboethoxyloratadine were observed following coadministration of loratadine with each of these drugs in normal volunteers (n = 24 in each study), there were no clinically relevant changes in the safety profile of loratadine, as assessed by electrocardiographic parameters, clinical laboratory tests, vital signs, and adverse events. There were no significant effects on QT, intervals, and no reports of sedation or syncope. No effects on plasma concentrations of cimetidine or ketoconazole were observed. Plasma concentrations (AUC 0-24 hrs) of erythromycin decreased 15% with coadministration of loratadine relative to that observed with erythromycin alone. The clinical relevance of this difference is unknown. These above findings are summarized in the following table:

Effects on Plasma Concentrations (AUC 0-24 hrs) of Loratadine and Descarboethoxyloratadine After 10 Days of Coadministration (Loratadine 10 mg) in Normal Volunteers		
	Loratadine	Descarboethoxyloratadine
Erythromycin (500 mg Q8h)	+ 40%	+46%
Cimetidine (300 mg QID)	+103%	+ 6%
Ketoconazole (200 mg Q12h)	+307%	+73%

There does not appear to be an increase in adverse events in subjects who received oral contraceptives and loratadine.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: In an 18-month carcinogenicity study in mice and a 2-year study in rats, loratadine was administered in the diet at doses up to 40 mg/kg (mice) and 25 mg/kg (rats). In the carcinogenicity studies, pharmacokinetic assessments were carried out to determine animal exposure to the drug. AUC data demonstrated that the exposure of mice given 40 mg/kg of loratadine was 3.6 (loratadine) and 18 (descarboethoxyloratadine) times higher than in humans given the maximum recommended daily oral dose. Exposure of rats given 25 mg/kg of loratadine was 28 (loratadine) and 67 (descarboethoxyloratadine) times higher than in humans given the maximum recommended daily oral dose. Male mice given 40 mg/kg had a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) than concurrent controls. In rats, a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) was observed in males given 10 mg/kg and males and females given 25 mg/kg. The clinical significance of these findings during long-term use of CLARITIN is not known.

In mutagenicity studies, there was no evidence of mutagenic potential in reverse (Ames) or forward point mutation (CHO-HGPRT) assays, or in the assay for DNA damage (rat primary hepatocyte unscheduled DNA assay) or in two assays for chromosomal aberrations (human peripheral blood lymphocyte clastogenesis assay and the mouse bone marrow erythrocyte micronucleus assay). In the mouse lymphoma assay, a positive finding occurred in the non-activated but not the activated phase of the study.

Decreased fertility in male rats, shown by lower female conception rates, occurred at an oral dose of 64 mg/kg (approximately 50 times the maximum recommended human daily oral dose on a mg/m² basis) and was reversible with cessation of dosing. Loratadine had no effect on male or female fertility or reproduction in the rat at an oral dose of approximately 24 mg/kg (approximately 20 times the maximum recommended human daily oral dose on a mg/m² basis).

Pregnancy Category B: There was no evidence of animal teratogenicity in studies performed in rats and rabbits at oral doses up to 96 mg/kg (approximately 75 times and 150 times, respectively, the maximum recommended human daily oral dose on a mg/m² basis). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, CLARITIN should be used during pregnancy only if clearly needed.

Nursing Mothers: Loratadine and its metabolite, descarboethoxyloratadine, pass easily into breast milk and achieve concentrations that are equivalent to plasma levels with an AUC_{milk}/AUC_{plasma} ratio of 1.17 and 0.85 for loratadine and descarboethoxyloratadine, respectively. Following a single oral dose of 40 mg, a small amount of loratadine and descarboethoxyloratadine was excreted into the breast milk (approximately 0.03% of 40 mg over 48 hours). A decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. Caution should be exercised when CLARITIN is administered to a nursing woman.

Pediatric Use: The safety of CLARITIN Syrup at a daily dose of 10 mg has been demonstrated in 188 pediatric patients 6-12 years of age in placebo-controlled 2-week trials. The effectiveness of CLARITIN for the treatment of seasonal allergic rhinitis and chronic idiopathic urticaria in this pediatric age group is based on an extrapolation of the demonstrated efficacy of CLARITIN in adults in these conditions and the likelihood that the disease course, pathophysiology, and the drug's effect are substantially similar to that of the adults. The recommended dose for the pediatric population is based on cross-study comparison of the pharmacokinetics of CLARITIN in adults and pediatric subjects and on the safety profile of loratadine in both adults and pediatric patients at doses equal to or higher than the recommended doses. The safety and effectiveness of CLARITIN in pediatric patients under 6 years of age have not been established.

ADVERSE REACTIONS: CLARITIN Tablets: Approximately 90,000 patients, aged 12 and older, received CLARITIN Tablets 10 mg once daily in controlled and uncontrolled studies. Placebo-controlled clinical trials at the recommended dose of 10 mg once a day varied from 2 weeks' to 6 months' duration. The rate of premature withdrawal from these trials was approximately 2% in both the treated and placebo groups.

REPORTED ADVERSE EVENTS WITH AN INCIDENCE OF MORE THAN 2% IN PLACEBO-CONTROLLED ALLERGIC RHINITIS CLINICAL TRIALS IN PATIENTS 12 YEARS OF AGE AND OLDER

PERCENT OF PATIENTS REPORTING			
LORATADINE 10 mg QD n = 1926	PLACEBO n = 2545	CLEMASTINE 1 mg BID n = 536	TERFENADINE 60 mg BID n = 684
Headache	12	11	8
Somnolence	8	6	22
Fatigue	4	3	10
Dry Mouth	3	2	4

Adverse events reported in placebo-controlled chronic idiopathic urticaria trials were similar to those reported in allergic rhinitis studies.

Adverse event rates did not appear to differ significantly based on age, sex, or race, although the number of nonwhite subjects was relatively small.

CLARITIN REDITABS (loratadine rapidly-disintegrating tablets): Approximately 10,000 patients received CLARITIN REDITABS (loratadine rapidly-disintegrating tablets) in controlled clinical trials of 2 weeks' duration. In these studies, adverse events were similar in type and frequency to those seen with CLARITIN Tablets and placebo.

Administration of CLARITIN REDITABS (loratadine rapidly-disintegrating tablets) did not result in an increased reporting frequency of mouth or tongue irritation.

CLARITIN Syrup: Approximately 300 pediatric patients 6 to 12 years of age received loratadine once daily in controlled clinical trials for a period of 8-15 days. Among these, 150 children were treated with 10 mg loratadine syrup once daily in placebo-controlled trials. Adverse events in these pediatric patients were observed to occur with type and frequency similar to those seen in the adult population. The rate of premature discontinuance due to adverse events among pediatric patients receiving loratadine 10 mg daily was less than 1%.

ADVERSE EVENTS OCCURRING WITH A FREQUENCY OF ≥ 2% IN LORATADINE SYRUP-TREATED PATIENTS (6-12 YEARS OLD) IN PLACEBO-CONTROLLED TRIALS AND MORE FREQUENTLY THAN IN THE PLACEBO GROUP

PERCENT OF PATIENTS REPORTING			
LORATADINE 10 mg QD n = 188	PLACEBO n = 262	CHLORPHENIRAMINE 2-4 mg BID/TID n = 170	
Nervousness	4	2	2
Wheezing	4	2	5
Fatigue	3	2	5
Hyperkinesia	3	1	1
Abdominal Pain	2	0	0
Conjunctivitis	2	<1	1
Dysphonia	2	<1	0
Malaise	2	0	1
Upper Respiratory Tract Infection	2	<1	0

In addition to those adverse events reported above (≥ 2%), the following adverse events have been reported in at least one patient in CLARITIN clinical trials in adult and pediatric patients:

Autonomic Nervous System: Altered lacrimation, altered salivation, flushing, hypotension, impotence, increased sweating, thirst.

Body As A Whole: Angioneurotic edema, asthenia, back pain, blurred vision, chest pain, ache, eye pain, fever, leg cramps, malaise, rigors, tinnitus, viral infection, weight gain.

Cardiovascular System: Hypertension, hypotension, palpitations, supraventricular arrhythmias, syncope, tachycardia.

Central and Peripheral Nervous System: Blepharospasm, dizziness, dysphonia, hypomigraine, paresthesia, tremor, vertigo.

Gastrointestinal System: Altered taste, anorexia, constipation, diarrhea, dyspepsia, flatulence, gastritis, hiccup, increased appetite, nausea, stomatitis, toothache, vomiting.

Musculoskeletal System: Arthralgia, myalgia.

Psychiatric: Agitation, amnesia, anxiety, confusion, decreased libido, depression, impaired concentration, insomnia, irritability, paroniria.

Reproductive System: Breast pain, dysmenorrhea, menorrhagia, vaginitis.

Respiratory System: Bronchitis, bronchospasm, coughing, dyspnea, epistaxis, hemoptysis, laryngitis, nasal dryness, pharyngitis, sinusitis, sneezing.

Skin and Appendages: Dermatitis, dry hair, dry skin, photosensitivity reaction, pruritus, purpura, rash, urticaria.

Urinary System: Altered micturition, urinary discoloration, urinary incontinence, urinary retention.

In addition, the following spontaneous adverse events have been reported rarely during marketing of loratadine: abnormal hepatic function, including jaundice, hepatitis, and liver necrosis; alopecia; anaphylaxis; breast enlargement; erythema multiforme; peripheral edema and seizures.

OVERDOSAGE: In adults, somnolence, tachycardia, and headache have been reported at overdoses greater than 10 mg with the Tablet formulation (40 to 180 mg). Extrapyramidal signs and palpitations have been reported in children with overdoses of greater than 10 mg CLARITIN Syrup. In the event of overdose, general symptomatic and supportive measures should be instituted promptly and maintained for as long as necessary.

Treatment of overdose would reasonably consist of emesis (ipecac syrup), except in patients with impaired consciousness, followed by the administration of activated charcoal to absorb any remaining drug. If vomiting is unsuccessful, or contraindicated, gastric lavage should be performed with normal saline. Saline cathartics may also be of value for rapid removal of bowel contents. Loratadine is not eliminated by hemodialysis. It is not known if loratadine is eliminated by peritoneal dialysis.

No deaths occurred at oral doses up to 5000 mg/kg in rats and mice (greater than 2400 and 1200 times, respectively, the maximum recommended human daily oral dose on a mg/m² basis). Single oral doses of loratadine showed no effects in rats, mice, and monkeys at doses up to 10 times the maximum recommended human daily oral dose on a mg/m² basis.

Schering

Schering Corporation
Kenilworth, NJ 07033 USA

1/97

19628400

CLARITIN REDITABS (loratadine rapidly-disintegrating tablets) are manufactured for Schering Corporation by Schering DDS, England.

U.S. Patent Nos. 4,282,233 and 4,371,516.

Copyright © 1997, Schering Corporation. All rights reserved.

Beyond Medicines that Help and Heal. What More Could You Expect from the Medicine Chest of the Nation?

Quite a lot more, based on a 1997 impact study conducted by Coopers & Lybrand L.L.P.* reporting that New Jersey's pharmaceutical and medical device companies make a significant contribution to just about every aspect of life in the Garden State.

For example, the pharmaceutical and medical device industry in New Jersey:

- *Generated \$8 billion in annual economic activity in 1996.*
- *Employs more than 60,000 workers from 115 locations in 70 municipalities in 16 counties.*
- *Paid \$3.2 billion in salaries and wages to employees in New Jersey.*
- *Leads research and development on serious and life-threatening diseases including cancer, Alzheimer's disease, heart disease, diabetes, arthritis, AIDS and osteoporosis.*
- *Received almost one-third of all FDA approvals of significant new drugs from 1991-1996.*

As the nation's medicine chest, New Jersey's research-based pharmaceutical and medical device companies are dedicated to meeting global healthcare needs while bolstering the Garden State's economy and improving the quality of life for all New Jerseyans.

**HealthCare
Institute of
New Jersey**



American Home Products Corp.
Becton Dickinson and Company
Bracco Diagnostics Inc.
Bristol-Myers Squibb Co.
C. R. Bard, Inc.
Hoffmann-La Roche Inc.
Hoechst Marion Roussel
Howmedica Inc. (Pfizer)

Johnson & Johnson
Knoll Pharmaceutical Company
Merck & Co., Inc.
Novartis Pharmaceuticals Corporation
Novo Nordisk Pharmaceuticals, Inc.
Nycomed Amersham Imaging Americas
Schering-Plough Corp.
Warner-Lambert Co.

*The Coopers & Lybrand findings draw upon survey information gathered from Institute members, as well as data available from public sources. The HealthCare Institute of New Jersey is a non-partisan trade association of 16 leading companies in New Jersey's research-based pharmaceutical, medical device and healthcare-related industries.

100 Albany Street
Suite 210
New Brunswick, NJ 08901
Ph: 732-342-8442
Fax: 732-342-8449

the difference is **EXCELLENCE**

For over half a century, excellence has kept Howmedica at the forefront of many developments and advances in orthopaedic surgery.

The **PRODUCT** Excellence that results from the fusion of scientific knowledge, pioneering research and inspired craftsmanship, has made Howmedica a leading innovator in orthopaedic technology in the world.

The **MANUFACTURING** Excellence associated with sophisticated, state-of-the-art, computer-integrated production methodologies, secures Howmedica a superior reputation for consistent high product quality and reliability.

The **CUSTOMER SERVICE** Excellence of one of the most comprehensive educational support programmes the industry knows, helps our representatives provide you with a full range of back-up and problem-solving resources - before, during and after purchase.

The **EXPERIENCE** Excellence that builds safety and ethical integrity into every product and procedure, and makes Howmedica such a valued and trusted partner in the treatment and care of your orthopaedic patients.

your orthopaedic resource worldwide.



Howmedica

Africa Howmedica International Ltd, London
Tel (44) 1784 444810
Asia Howmedica Asia Regional Office, Sydney,
Tel (61) 2 9850 3900
Australia Howmedica Australia, Sydney, NSW
Tel (61) 2 9850 3900
Austria Howmedica Austria GmbH, Vienna
Tel (43) 1 545 1611
Belgium Howmedica Belgium, Zaventem
Tel (32) 2722 0356
Brazil Howmedica Brazil, Guarulhos (SP)
Tel (55) 11 6464 7666
Canada Howmedica Canada, Guelph
Tel (519) 824 1140
Denmark Howmedica Denmark, Copenhagen
Tel (45) 339 36099
Eastern Europe Howmedica GmbH, Kiel
Tel (49) 4348 7020

Finland Howmedica Finland, Helsinki
Tel (358) 9773 2277
France Howmedica France, Lyon Tel (33) 4 78 78 60 60
Germany Howmedica GmbH, Kiel Tel (49) 4348 7020
Greece Howmedica Greece, Athens
Tel (30) 1 3304318
Hong Kong Hong Kong Surgical Products Ltd,
Hong Kong Tel (852) 2527 9974
India Howmedica India, Bombay
Tel (91) 22 287 2279
Indonesia Atra Widiya Agung, Jakarta
Tel (62) 21 7507 707
Ireland Howmedica Ireland, Shannon
Tel (353) 61 471866
Italy Howmedica Italy, Rome Tel (39) 6 33182
Japan Howmedica Japan, Tokyo
Tel (81) 3 33447523
Korea Howmedica Korea, Seoul Tel (82) 2 447 6971

Malaysia Medimax, Kuala Lumpur Tel (603) 793 8389
Middle East Howmedica International Ltd, London
Tel (44) 1784 444810
Netherlands Howmedica Netherlands, Haarlem
Tel (31) 23 5 28 90 55
New Zealand Howmedica New Zealand, Auckland
Tel (64) 95250577
Norway Howmedica Norway, Oslo Tel (47) 2 242 22 44
Pakistan Ortho Surg, Karachi Tel (92) 21 241 2232
Portugal Pfizer Inc, Coia Tel (351) 1 2278200
Puerto Rico Howmedica Puerto Rico, Carolina
Tel (787) 257 5072
Singapore Point Surgical Supplies, Singapore
Tel (65) 4590 142
Spain Howmedica Iberica SA, Madrid
Tel (34) 1 358 0369
Sweden Howmedica Sweden, Malmo
Tel (46) 4015 90 30

Switzerland Howmedica Switzerland, Gen
Tel (41) 22 884 01 19
Taiwan Howmedica Taiwan, Taipei
Tel (886) 2 809 7979
Thailand Indochina Healthcare Ltd, Bangkok
Tel (66) 2 513 9909
United Kingdom Howmedica International
London Tel (44) 181 896 7600
USA Howmedica Inc, Rutherford NJ
Tel (201) 507 7300

▲ Visit us on the worldwide web at:
<http://www.howmedica.com>



PUBLIC & PRIVATE HEALTH CARE PARTNERSHIPS

THEY ARE THE BACKBONE OF PROGRAMS FOR THE MEDICALLY UNDERSERVED. THEY WORK TO IMPROVE THE HEALTH OF ALL NEW JERSEYANS. PHARMACEUTICAL AND MEDICAL DEVICE COMPANIES PULL THEIR WEIGHT WHEN IT COMES TO CONTRIBUTING TO THE HEALTHY LIVES OF NEW JERSEYANS.

Pharmaceutical and medical device companies are reaching out to a wide variety of public sector groups to develop groundbreaking collaborations aimed at improving the health of patients and, more broadly, the quality, availability, and affordability of

health care. Companies are teaming up with government agencies, academia, state disease organizations, community service agencies, and patient



Dr. Irwin Redlener, president and co-founder of The Children's Health Fund, announces a program dealing with asthma specialty services.

advocacy groups. The reach of these efforts can be international, national, or focused in New Jersey.

Some innovative programs address unmet medical and patient needs within the state. An asthma prevention and treatment program, an initiative between Schering-Plough and The Children's Health Fund (CHF), involves direct interventions with medically underserved youth in inner cities.

The first leg of the program focused on New York City's medically underserved. This year, New Jersey children will be the recipients of the program's second phase, through which Saint Barnabas Medical Center will provide primary medical care and asthma specialty services to children in Newark, Elizabeth, and Union County through a dedicated CHF mobile unit.

"Asthma is at its worst in inner-city areas because these areas present a host of agents that can aggravate the condition, including indoor and outdoor allergens, and crowded conditions that can breed respiratory infections, not to mention the effects of stress and tobacco smoke," says Irwin Redlener, MD, CHF president and co-founder. Another inner-city partnership is being conducted by CAMcare Health Corporation, the largest community health center in Camden, through a grant from Johnson & Johnson. The company's funding has enabled CAMcare to hire a nutritionist to educate the city's adolescents on how to manage risk factors, such as HDL

cholesterol and obesity, which put them at higher risk for developing chronic conditions. "The program will reach 20 to 25 percent of the population—between 6,000 and 8,000 people—through classes and direct consultation with our staff nutritionist," according to Mark Bryant, CAMcare president and CEO.

Other industry programs focus on adult patient education for conditions that, at least in part, have a behavioral or psychological basis. A new program by Knoll Pharmaceutical Company is focused on weight management. Called "Point of Change," it offers patients tailored, personalized interventions that are developed based on their own demographics, expectations, and individual weight loss motivators. "Point of Change reflects current thinking in clinical and behavioral circles that programs involving relatively small-scale, nonthreatening interventions work better than big, dramatic undertakings," explains MSNJ member Kenneth Storch, MD, a Florham Park nutrition and metabolism specialist.

Two other companies have developed programs that provide psychosocial support for patients and their families affected by mental illness. Janssen Pharmaceutica is

offering the first national public-private partnership to help patients on antipsychotic medication become reintegrated into society. Called "Person-to-Person," the program involves a broad coalition of mental health organizations in a program that helps people suffering from schizophrenia and other severe psychoses build durable ties to long-term support networks in their communities. Person-to-Person is staffed seven days a week, 15 hours a day by telephone information counselors. Lois Weissman, a certified adult mental health nurse at Community Centers for Mental Health, states, "My patients know that the toll-free telephone line is one of the four or five supports they can contact if they are experiencing a problem, not as a substitute for a professional therapist or case manager, but as a reinforcement. Through the program, they are reminded of their doctors' appointments and medication checks, and helped to stay oriented with their daily activities."

Wyeth-Ayerst has formed an alliance with the National Depressive and Manic-Depressive Association to introduce "Wyeth-Ayerst Connexions: The Depression Family Support Program." The program is designed to increase awareness about the impact of depression on the entire family and the vital role the family can play in the management of this disease.

"The program gives primary care physicians access to a program that addresses an aspect of depression that often gets neglected, such as the impact of the disease on family dynamics and how family members can cope with depression when it strikes," explains MSNJ member

"POINT OF CHANGE"

OFFERS PATIENTS A
TAILORED, PERSONALIZED
INTERVENTION BASED ON
SPECIFIC NEEDS AND
EXPECTATIONS.

Eric Munoz, MD, director, medical affairs, University of Dentistry of New Jersey—University Hospital.

Ortho Biotech has partnered with Cancer Care to bring to patients across the country "Living with Cancer Learning Series" teleconferences, through which they participate in

live discussions with health care professionals and other cancer patients on cancer-related topics, including fatigue, employment issues, coping strategies for caregivers, and managed care issues. The teleconferences are popular in New Jersey, accounting for one-quarter of the nation's total participants, according to Joan Runfola, director of social services for Cancer Care's New Jersey affiliate.

On a national and global basis, New Jersey companies also are teaming up with physicians, pharmacists, and other health care professionals

to address broad issues affecting the delivery and availability of health care. New Jersey companies are among 35 organizations that comprise "Pharmaceutical Partners for Better Healthcare" (PPBH), a think tank that partners with ministries of health, providers, insurers, and patients to encourage a collaborative working relationship among all parts of the health care sector—a requirement for addressing some of the difficult issues facing health care today. PPBH stimulated the first meeting of patient groups from around the world and, ultimately, the formation of an international patient organization with more than 100 member patient groups. Christina Funnell, a patient advocate from the United Kingdom, served as a consultant to the group. "The international meeting served as a forum for patient organizations from more sophisticated countries to share information with other European and developing nations so that we can begin to dialogue and voice opinion in a more trans-national fashion about global health care issues," she explains.

Nationally, nearly 100 health care companies, members of the Pharmaceutical Research and Manufacturers Association (PhRMA), have worked with physicians, pharmacists, and patient and minority organizations on a variety of issues. PhRMA companies most recently collaborated with the National Health Council, the American Association of Medical Colleges, and patient groups to address issues related to our nation's ability to protect the future of biomedical research. ■

Making a Difference

Roxanne Black started the organization as a hobby from her Rutgers University dormitory room using only a set of index cards. Less than a decade later, Friends' Health Connection (FHC) was the recipient of the 1997 Governor's Volunteer Award in the category of health. "We're a nonprofit support network that connects people of all ages with similar diseases, injuries, or handicaps for the purpose of mutual support," explains Black, who was diagnosed with systemic lupus at age 15. "We like to think of ourselves as the nation's primary source of customized emotional support."



Roxanne Black (right) receives an award from Governor Whitman.

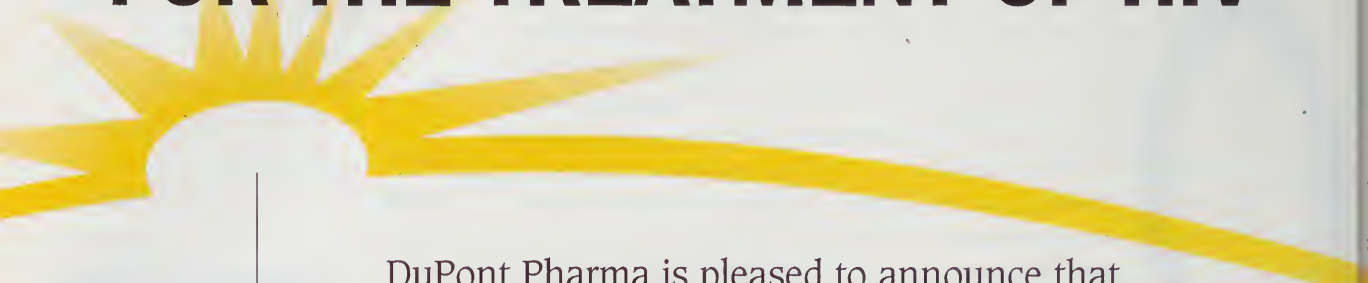
Black continued her index-card-based matching system until the organization became the focus of national media coverage—notably, the Oprah Winfrey Show and *USA Today*. This increased visibility led to the donation of a computer and an initial start-up grant from Johnson & Johnson. Since that time FHC has gained the support of other state health care companies,

including Novartis, Hoffmann-La Roche, and Bristol-Myers Squibb.

In 1995, the organization received a grant from Roche to study the impact of the organization's support efforts, which showed that emotional attitudes of participants did improve. The company then funded a pilot awareness study with seven state hospitals, the success of which now has led to a full-blown communications and referral program in conjunction with the New Jersey Hospital Association.

SUSTIVA™ (efavirenz)

EXPANDED ACCESS PROGRAM FOR THE TREATMENT OF HIV



DuPont Pharma is pleased to announce that SUSTIVA™ (formerly known as DMP 266) is available through an expanded access program. SUSTIVA is a new investigational non-nucleoside reverse transcriptase inhibitor for use in combination therapy for HIV disease.

The SUSTIVA Expanded Access Program is open to HIV-positive patients 13 years of age or older who are unable to tolerate, or are failing to respond to their current regimens and who meet the entry criteria.

EXPANDED INCLUSION CRITERIA now allow enrollment of patients with $CD_4 \leq 400$ cells/mm³ at any point in their history. There continues to be no requirement for viral load.

If you have patients who might benefit from the SUSTIVA Expanded Access Program, or if you would like more information including the program protocol, please call the toll-free number below.



SUSTIVA™
efavirenz

Call the SUSTIVA
Expanded Access Program
at **1-800-998-6854**

<http://www.hiv.dupontmerck.com>



Excel Business Park

501 Prospect Street

Unit 96

Lakewood, NJ 08701

Phone: 732•886•0600

Fax: 732•886•0911

"The overall effect is total customer satisfaction."

- Medical/Dental Cabinetry
- Nurses Stations
- Reception Desks
- Nourishment Centers
- Medical/Dental Procedure Carts
- Computer Desks
- Monitor Cabinets
- Chart Racks
- Corian® Solid Surfacing
Certified Fabricator #C-5112
- Space Planning/Layout

**Ask the
right questions...**
**Make the
right choices...**

Watch this special
Caucus: New Jersey public television
series and get the information
you need to make informed health care
decisions for you and your family.

caucus
NEW JERSEY
www.caucusnj.org



Hosted by Steve Aduabato

Informed Choices has been produced in association with UMDNJ,
The University of Medicine and Dentistry of New Jersey

UMD
NEW JERSEY

Funded by



Caucus: New Jersey is a co-production of the Caucus Educational Corporation,
Rutgers-Newark, NJN-Public Television and Thirteen/WNET.

**Informed
Choices**

Informed Choices on Cancer



Thirteen/WNET
May 2 at 12:30pm
May 3 at 6:00am



NJN - Public Television
May 3 at 10:00am
May 6 at 6:30pm

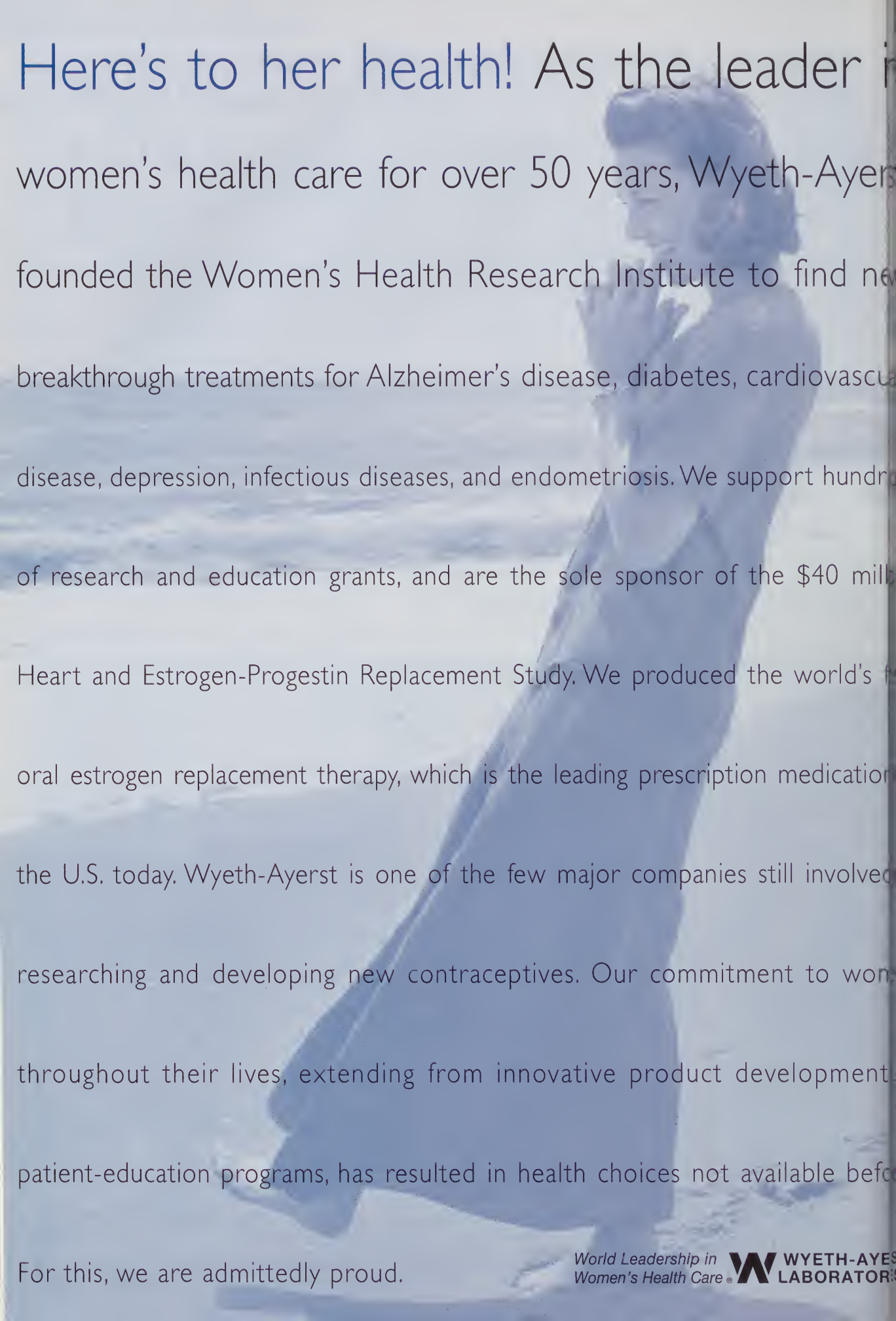
Informed Choices on Violence



Thirteen/WNET
May 9 at 12:30pm
May 10 at 6:00am



NJN - Public Television
May 10 at 10:00am
May 13 at 6:30pm

A woman in a long, dark, flowing dress is walking on a sandy beach. She is looking down at her hands, which are clasped together in front of her. The background is a soft, out-of-focus view of the ocean and sky. The overall tone is serene and contemplative.

Here's to her health! As the leader in women's health care for over 50 years, Wyeth-Ayerst founded the Women's Health Research Institute to find new breakthrough treatments for Alzheimer's disease, diabetes, cardiovascular disease, depression, infectious diseases, and endometriosis. We support hundreds of research and education grants, and are the sole sponsor of the \$40 million Heart and Estrogen-Progestin Replacement Study. We produced the world's first oral estrogen replacement therapy, which is the leading prescription medication in the U.S. today. Wyeth-Ayerst is one of the few major companies still involved in researching and developing new contraceptives. Our commitment to women throughout their lives, extending from innovative product development to patient-education programs, has resulted in health choices not available before.

For this, we are admittedly proud.

World Leadership in
Women's Health Care  **WYETH-AYERST
LABORATORIES**

SIX UNSUNG HEROES

WHAT MOTIVATES SOMEONE TO GO ABOVE AND BEYOND THE CALL OF DUTY? SIX INDIVIDUALS PROVE THAT WHERE THERE IS A WILL, THERE IS A WAY. THEY ARE MAKING HISTORY THROUGH PERSONAL CRUSADES IN THE PHARMACEUTICAL WORKPLACE AND THEY ARE BRINGING HOPE TO MILLIONS. WITH THEIR DEDICATION, THESE NEW JERSEYANS ARE DEMONSTRATING THE POWER AND PERSEVERANCE OF COMMITMENT.



Since 1992, Susan Light, MD, medical director, Transplantation, Hoffmann-La Roche, Inc., led a research team that is responsible for the development of a new monoclonal antibody to prevent kidney transplant rejection.

In 1992, Light gave birth to Jake, who was diagnosed with a polycystic kidney disease. So far, Jake is doing well, but eventually he will receive a kidney from his mother. Commenting about her experiences, Light remarks, "It helped me cope by knowing I could do something that has potential not just for Jake; but I have a real kinship with all the other kids who have this disease."

For ten years, a research team at Merck studied a new antiviral compound for the treatment of adults with HIV infection. The decade of progress was filled with dramatic

Susan Light and her son reflect on the research that has changed their lives.

highs and lows, during which researchers developed an emotional commitment grounded in compassion for those suffering from the deadly infection. During this time, the compound's lead researcher, Dr. Irving Sigal, was killed in the terrorist bombing of PanAm Flight 103 over Scotland. While his untimely death was devastating to those who had worked closely with him, the team quickly rejoined the quest. Dedicating their efforts to the memory of the scientific leader they had lost, the team brought Merck's drug, Crixivan®, to market in record-breaking time: three years from discovery to market.

Having experienced her first seizure at age 15, Theresa Bachman, neurology sales specialist, Novartis, has a special empathy for what epilepsy patients are experiencing as she discusses the company's products with providers throughout the state. "My personal experiences make it much easier for me to talk with physicians about why quality of life should be such an



Theresa Bachman travels around the state as a neurology sales specialist.

important consideration for their patients."

Over the past seven years, Don Cutshall, director, Quality Management and Regulatory Compliance, Becton Dickinson, has organized teams within the company that have raised more than \$20,000 for the New Jersey chapter of the American Diabetes Association through their annual "Tour de Cure" fundraiser. Cycling 60 miles in the event each year, he says, "Not

only do I have fun, but I feel really good knowing that I'm riding for a good cause that helps others who are less fortunate than myself."

Since 1985, Barbara Grill and Barbara Chango, executive secretaries, Ortho-McNeil Pharmaceutical, have spearheaded an effort within the company's finance and information management divisions through which 40 company volunteers donate their lunch hours to deliver meals to the elderly through the Somerset County Office on

Tour de Cure participants get ready for another cycling event.



Aging. "Participating in the program triggers a mix of emotions," said Chango. "At the very least, it gives you hope that if you are ever in a similar situation, someone will do the same for you."

Ever wish your broker, your trust officer
and your banker had more in common?



A single vision of your future, for example?

As a physician, you spend a lot of time serving your patients and managing your practice. Where do you find the time to manage the people who manage your financial affairs? At PNC Private Bank, the team of people that manage your financial affairs can be just that: a team. People who work together, with a common goal: to realize your vision of the future. PNC Private Bank brings together under

one roof every service you need, backed by 150 years of professional money management experience and the resources of one of the country's largest financial institutions. No conflicts of interest. No misinterpretations. Just the synergy that can only come when everyone who works with you works with each other as well. Call 1-888-844-1565 to learn more about the difference at PNC Private Bank.

PNC PRIVATE BANKSM

Visit us on the World Wide Web. Our address is <http://www.pncbank.com>

Investments • Trusts • Banking Services

PNC Private Bank is a service mark of PNC Bank Corp. Banking and trust services are provided: by PNC Bank, National Association in Pennsylvania, New Jersey, Kentucky, Ohio and Indiana; by PNC Bank, New England in Massachusetts and Connecticut; by PNC Bank, Delaware in Delaware; and by PNC Bank, FSB in Florida. Members FDIC. Brokerage services are offered through PNC Brokerage Corp, a registered broker-dealer and member SIPC. PNC Brokerage Corp is a subsidiary of PNC Bank, National Association, which is not a broker-dealer.

We know that practicing medicine is your primary concern.

The professionals at Healthcare Management Partners will take away the time-consuming administration and pressures of billing, collections, follow-up, office management, and system maintenance, so you can concentrate on doing what you do best - practicing medicine.

Contact Rosalie Fox or Robert Rahl at 609-734-0443 to find out more.

**Practice Assessments • Billing & Collection •
MIS Systems • Group Practice Formation •
Practice Management • Income Distribution**

**Endorsed Computerized Billing,
Accounts Receivable and
Information Management Company of the
Medical Society of New Jersey**



HEALTHCARE MANAGEMENT PARTNERS

PARTNERS IN PROFIT

200 Canal Pointe Boulevard • Princeton, NJ 08540-5998
609-734-0443 • FAX 609-243-9799

A Division of Health Information Consulting Services, Inc.

Direct AccessSM

for small employers

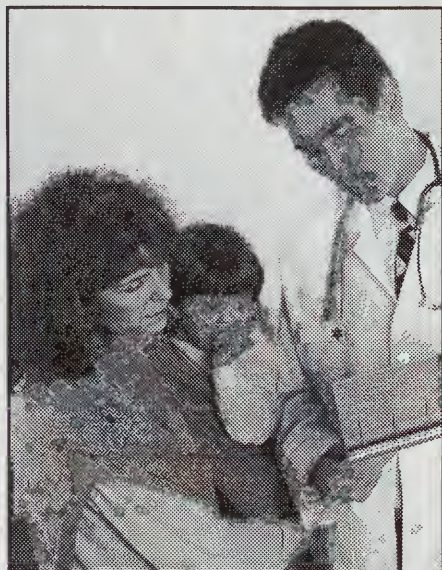
Visit a specialist
without a referral.

Nationwide access to over 300,000
participating doctors, specialists and hospitals.

Value added discounts for you and your employees from
Blue Vision and CompUSA.

And, announcing a \$25,000 *life insurance program* for small
employer groups that join the MSNJ/BCBSNJ program!

This and more is available when you choose the new
Direct Access health plan from Blue Cross and Blue Shield of
New Jersey—The Medical Society of New Jersey's health
carrier of choice for its members!



BlueCross BlueShield
of New Jersey

Ask us for a free
copy of the SEH
Buyer's Guide.

For more information on Direct Access, and other
health plans for individuals, families
and small employers,
contact the Medical Society of New Jersey's
exclusive BCBSNJ representative:

Medical Society of New Jersey
MSNJ

Jennifer Altobelli
Sales Representative
973-338-0893

Our doctors aren't just great. They're the best.



Hudson County's best doctors practice at St. Mary Hospital of Hoboken and St. Francis Hospital of Jersey City. With nearly 600 skilled, caring professionals, our medical staff includes a growing number of leading specialists who are nationally-recognized experts in fields like perinatology, internal medicine and psychiatry.

So when you're looking for a doctor, choose the best.
Call (201) 418-2020.

**ST. FRANCIS
HOSPITAL**
of Jersey City

**ST. MARY
HOSPITAL**
of Hoboken

The best doctors and nurses. Right in your neighborhood.™

MANAGING HIV/AIDS PATIENTS

IT'S NOW IN YOUR POWER. YOU CAN HELP TO STOP THE RAVAGES OF HIV/AIDS. NEW MEDICAL ADVANCES OFFER A MORE HIGHLY EFFECTIVE TREATMENT REGIMEN FOR HIV/AIDS PATIENTS. CLINICIANS MUST INCORPORATE NEW LABORATORY TESTS AND MORE POTENT ANTIRETROVIRAL AGENTS INTO THE MEDICAL MANAGEMENT OF PATIENTS WITH HIV/AIDS.

*By Sindy M. Paul, MD, MPH; John Sensakovic, MD, PhD;
Linda S. Podhurst, PhD; Douglas H. Morgan, MPA; Warren Triano-Davis, MPA*

The past two years have brought dramatic advances in both AIDS research and the medical management of HIV/AIDS. Clinicians now must incorporate new laboratory tests and numerous, more potent antiretroviral agents into the medical management of patients with HIV/AIDS.

Viral load testing has provided the opportunity to monitor the amount of virus in the plasma. Viral load is a powerful predictor of the individual patient's risk of disease progression to AIDS and time to death.¹ It has rapidly become an important laboratory tool to assist in decisions regarding antiretroviral therapy.

The recommended medical regimen is comprised of multiple antiretroviral agents in an appropriate combination to inhibit HIV replication with the goal of suppressing HIV

replication to such an extent that ideally the patient has an undetectable viral load. The following treatment guidelines are designed to assist clinicians and patients in making informed decisions regarding treatment options keeping in mind that effective antiretroviral therapy should be introduced prior to the occurrence of extensive immune system damage; that ongoing HIV replication leads to immune system damage and progression to AIDS; the role of viral load monitoring in the decision-making process; suggestions

regarding combination therapy; the need to individualize treatment decisions based on the level of risk indicated by the viral load and CD4⁺ T cell counts; the need for adherence to the prescribed regimen; and the need to prevent development of antiretro-



Emilio Emini, a Merck scientist at work on AIDS research.

viral resistant strains of HIV. Each of the antiretroviral agents in the combination regimen should be used according to the optimum schedule and dosage.²

The complex regimens recommended in the new treatment guidelines offer great promise. To achieve success, clinicians and patients must work in a partnership to develop strategies that will ensure adherence to these regimens. Inadequate adherence allows the virus to continue to replicate and increases the likelihood of resistant mutations. This jeopardizes the chance for effective treatment. It is, therefore, necessary to discuss the importance of compliance with patients in prescribing antiretroviral agents.

Patients must be able and willing to closely follow the dosing, timing, and diet requirements to realize the benefits of combination therapy. As partners, clinicians need the skills to elicit and understand the constraints, preferences, and limitations of patients' lifestyles in order to offer the most appropriate combination for each patient. The selection of therapy must be highly individualized and must result from a clear understanding of the patient's ability and willingness to adhere to a particular regimen; adherence can-

not be predicted by group association. It is vital that the growth in knowledge in HIV clinical care is accompanied by the highest quality of communication in the provider-patient relationship. Treatment regimens must be the result of mutual decision making, offered along with personalized cues and reminders that help patients manage their regimens. Successful communication and effective adherence strategies may greatly improve the quality of life for HIV-infected patients. Failing this not only risks losing the benefits of the clinical advances for the individual patients, it also may contribute to the transmission of resistant strains of HIV, which has major public health consequences.

The care and treatment of persons with HIV disease is difficult and requires many considerations before initiating therapy. With the rapidly changing, increasingly complex combination therapy for HIV/AIDS, it may be necessary to refer an increasing number of HIV/AIDS patients for consultation.

COMPLEX REGIMENS NOW
RECOMMENDED IN THE
NEW TREATMENT
GUIDELINES OFFER
GREAT PROMISE.

Before starting any patient on antiretroviral therapy, verify that the patient is HIV positive. This would entail repeat HIV testing for patients reporting a seropositive result from anonymous or home testing. This confirmatory testing should be done by a licensed laboratory using a FDA approved test.

Both CD4 T cell counts and viral load testing are important laboratory tests in the medical management of patients with HIV/AIDS; both play a role as prognostic markers of HIV-1 infection.³ CD4 counts remain the best marker for immune system status.

Viral load testing, which was recently approved by the FDA, measures the amount of virus present. It is used prior to the initiation of therapy, to gauge the effectiveness of treatment, and to decide whether to change therapy.

There are different types of viral load assays; they are not equivalent. The same assay should be used for the same patient. Other factors that may affect the results, in addition to assay type, include collection anticoagulant (EDTA is the best, so a purple top tube should be used), processing, and storage. Infections and immunizations may temporarily elevate viral load. Therefore, viral load should not be measured during or within four weeks after successful treatment of intercurrent infection, resolution of symptomatic illness, or immunization.⁴

Viral load should be obtained as part of the initial evaluation of newly diagnosed HIV infection; on two occasions if clinically indicated (prior to initiation or changing therapy); four weeks after initiating or changing therapy; three to four months after initiating or changing therapy; periodically on the same schedule as CD4 counts, e.g. every three to four months, for patients on or not on therapy; for patients with a syndrome consistent with acute HIV infection; and when a clinical event or decline in CD4+ T cells occurs.⁵

The long-term goal of antiretroviral therapy is to sustain a significant decrease in viral load, ideally below detectable levels. Differences of more than threefold or 0.5 log on repeated measures of plasma HIV RNA likely reflect biologically and clinically relevant changes.⁵

To date, consensus has not been reached as to an exact antiretroviral therapy regimen to use. For practical purposes at this point, many experts recommend three drug regimens that usually include two nucleoside analog reverse transcriptase inhibitors (NRTI) and a protease inhibitor. Physicians will need to use their judgment to develop individualized regimens for their patients.



There are, however, some general guidelines: combination therapy is regarded as superior to monotherapy; regimens should be selected to minimize the risk of developing resistance; and a long-term treatment strategy needs to be developed for each patient because initial treatment can impact future changes.⁵

Many experts would recommend antiretroviral therapy for all patients who demonstrate laboratory evidence of acute HIV infection. Acute HIV infection is defined as a detectable HIV RNA in plasma using sensitive PCR or DNA assays together with a negative or indeterminate HIV antibody test. While HIV RNA is preferable, p24 antigen may be useful when RNA testing is not readily available. Apart from patients with acute primary HIV infection, many experts would consider therapy for patients in whom seroconversion has been documented to have occurred within the previous six months.⁵

The decision to start therapy in asymptomatic patients is complex and must be made in a setting of careful patient counseling and education. The factors that must be considered in this decision include: willingness of the individual to start therapy; the degree of existing immunodeficiency as determined by the CD4+ T cell count; the risk of disease progression as determined by the level of plasma HIV RNA; potential benefits and risks of initiating therapy in asymptomatic individuals; and the likelihood after education and counseling of adherence to the prescribed regimen. Notwithstanding this, every person with HIV regardless of membership in any group, should be offered all medically appropriate treatment.⁵

In current practice, there are two general approaches to initiating therapy in asymptomatic patients. The aggressive approach is based on the principle that treatment should begin before the development of significant immunosuppression and one should treat to achieve undetectable viremia. The more conservative approach to the initiation of therapy in the asymptomatic patient would delay treatment of patients with <500 CD4+ T cells/mm³ and low levels of viremia who have a low risk of rapid disease progression. Patients with CD4+ T cell counts >500/mm³ also would be observed except those with a substantial risk of rapid disease progression due to a high viral load.⁵

When initiating therapy in a patient naive to antiretroviral therapy, one should begin with a regimen that is expected to reduce viral replication to undetectable levels.⁵

Initiation of treatment in asymptomatic patients should be considered for patients fulfilling the following criteria:

- Asymptomatic, CD4 <500 cells/mm³ or >10,000 (bDNA) or >20,000 (RT-PCR) copies of HIV RNA/ml plasma; or
- Asymptomatic, CD4 >500 cells/mm³ and viral load is >10,000 (bDNA) or >20,000 (RT-PCR) copies of HIV RNA/ml plasma.⁵

However, some experts recommend therapy for patients with 5,000 to 10,000 (RT-PCR) copies of HIV RNA/ml of plasma regardless of the CD4 count.⁶

Initiation of treatment may be considered for asymptomatic patients fulfilling the following criteria:

- Asymptomatic, CD4 >500 cells/mm³ and viral load is <10,000 (bDNA) or <20,000 (RT-PCR) copies of HIV RNA/ml plasma; or
- Asymptomatic, CD4+ T cell counts between 350-500 mm³ and HIV RNA levels <10,000 (bDNA) or <20,000 (RT-PCR) copies of HIV RNA/ml plasma.⁵

However, some experts recommend therapy for patients with

5,000 to 10,000 (RT-PCR) copies of HIV RNA/ml of plasma regardless of the CD4 count.⁶

All patients diagnosed with advanced HIV disease, defined as any condition meeting the 1993 CDC definition of AIDS, should be treated with antiretroviral agents regardless of plasma viral levels. All patients diagnosed with symptomatic HIV infection without AIDS, defined as the presence of thrush or unexplained fever, also should be treated.⁵

When a patient is acutely ill with an opportunistic infection or other complication of HIV infection, clinical issues such as drug toxicity, ability to adhere to treatment regimens, drug interactions, and laboratory abnormalities should be considered. Once therapy is initiated, a maximally suppressive regimen such as two NRTIs and a protease inhibitor should be used. Advanced stage patients on an antiretroviral regimen should not have the therapy discontinued during an acute opportunistic infection or malignancy, unless there are concerns

regarding drug toxicity, intolerance, or drug interactions.⁵

There are multiple reasons for temporary discontinuation of antiretroviral therapy, including intolerable side effects, drug interactions, and unavailability of drug. For pregnancy-related issues, professionals should read the U.S. Public Health Services "Recommendations for the Use of Antiretroviral Drugs During Pregnancy for Maternal Health and Reduction of Perinatal Transmission of HIV-1." If there is a need to discontinue any antiretroviral medication for an extended time, clinicians and patients should be advised of the theoretical advantage of stopping all antiretroviral agents simultaneously, rather than continuing one or two agents, to minimize the emergence of resistant viral strains.⁵

As with the initiation of antiretroviral agents, the decision to change regimens should be approached with careful consideration of recent clinical history and physical examination; plasma HIV RNA levels measured on two separate occasions if clinically indicated; absolute CD4+ T cell count and changes in these counts; remaining treatment options in terms of potency, potential resistance patterns from prior antiretroviral therapies, and potential for compliance/tolerance; assessment of adherence to medications; and

**ALL PATIENTS WITH
ADVANCED HIV DISEASE
SHOULD BE TREATED
WITH ANTIRETROVIRAL
AGENTS.**

preparation of the patient for the implications of the new regimen, which includes side effects, drug interactions, dietary requirements, and possible need to alter concomitant medications. In this regard, it is important to carefully assess patient compliance prior to changing antiretroviral therapy, as rising HIV RNA levels may be due to poor compliance or inadequate patient education about the therapeutic agents.⁵

It is important to distinguish between the need to change therapy due to drug failure versus drug toxicity. In the latter case, it is appropriate to substitute one or more alternative drugs of the same potency and from the same class of agents as the agent suspected to be causing toxicity. In the case of drug failure where more than one drug has been used, history of current and past antiretroviral medications, as well as other HIV-related medications should be obtained. Optimally and when possible, the regimen should be changed entirely to drugs that have not been taken previously. With triple combination of drugs, at least two and preferably three new drugs must be used.⁵

A final consideration in the decision to change therapy is the recognition of the still limited choice of available agents and the knowledge that a decision to change may reduce future treatment options for the patient.⁵

RISING HIV RNA LEVELS MAY BE DUE TO POOR COMPLIANCE OR INADEQUATE PATIENT EDUCATION.

Consideration should be given to changing therapy when the following criteria are met.

- Less than a tenfold (1.0 log) reduction in plasma HIV RNA by four weeks following initiation of therapy.
- Failure to suppress plasma HIV RNA to undetectable levels within four to six months of initiating therapy. The degree of initial decrease in plasma HIV RNA also should be considered.
- Repeated detection of virus in plasma after initial suppression to undetectable levels. The degree of plasma HIV RNA also should be considered, e.g. the physician may consider short-term observation in a patient whose plasma HIV RNA increases from undetectable to detectable (5,000 copies per ml) at four months.
- Any reproducible significant increase, defined as threefold or greater, from the nadir of plasma HIV RNA not attributable to intercurrent infection, vaccination, or test methodology.

- Persistently declining CD4+ T cells numbers, as measured on at least two separate occasions.

- Clinical deterioration.
- Toxicity, intolerance, or non-adherence.

- Current regimen is suboptimal.⁵

Although the recent advances in the medical management of HIV/AIDS are beneficial for quality of life and have been attributed as a factor in the declining mortality rate among AIDS patients, there still is no cure for HIV/AIDS.⁷ Prevention remains extremely important. HIV-infected persons, even those with an undetectable viral load should be considered infectious. It is essential that detailed sexual and drug use histories be taken on each and every patient. The clinician must assess each patient's risk for transmitting HIV both sexually and via injection drug use. Once risk behaviors have been identified, an HIV prevention intervention specific to each behavior should be discussed thoroughly with the patient. The discussion should be accompanied by an assessment of skills, such as how to use a condom, and, if necessary, demonstration of condom use. Interrupting transmission of HIV from patients already infected to sexual or drug use partners is essential to controlling the growth of the epidemic. Clinicians can play an important role in that process by ensuring that

their patients with HIV infection have the knowledge and skills to prevent additional cases.

The New Jersey Department of Health and Senior Services (DHSS) has a Notification Assistance Program (NAP), which includes confidential field investigation of the sexual and needle-sharing partners of HIV-infected individuals and post-test followup of confidentially tested HIV positive clients, who fail to return for their test results. NAP individually educates those persons who have been exposed to or infected with HIV about transmission, risk reduction, and the consequences of their behavior(s) to allow individuals to make informed decisions about future behaviors and plans. Counseling coupled with referrals to test sites and/or other support agencies attempts to break the cycle of HIV transmission through awareness and education while simultaneously providing a vehicle for persons to gain access to the systems that have been established and are available to persons touched by the AIDS epidemic. Any health care provider can contact NAP by calling DHSS at 201.648.7500.

HIV infection and AIDS are reportable to DHSS. According to

the New Jersey Administrative Code, physicians are required to report a patient who is diagnosed with HIV infection, whether a test was performed or not (8:57-2.1-2.7). For example, if a physician diagnoses HIV infection based on a patient's history, physical examination, and other laboratory results, a confidential HIV/AIDS case report must be submitted. A case report also must be submitted when a patient is diagnosed with AIDS, regardless of whether the same physician reported the HIV infection or not. For additional information, forms/instructions, or questions, contact the DHSS Surveillance Program at 609.984.5940.

References

1. Mellors JW, Rinaldo CR, Gupta P, et al.: Prognosis in HIV-1 infection predicted by the quantity of virus in plasma. *Science* 272:1167-1170, 1996.
2. Carpenter C, Feinberg M, Aubry W, et al.: Report of the panel

to define principles of therapy of HIV infection. DHHS, 1997.

3. Mellors JW, Munoz A, Giorgi JV, et al.: Plasma viral load and CD4+ lymphocytes as prognostic markers of HIV-1 infection. *Ann Intern Med* 126:946-954, 1997.
4. Paul SM, Brown JW, Gorney MG, et al.: One world one hope AIDS 11th international conference overview. *Medical Laboratory Observer* 28:24-38, 1996.
5. Fauci AS, Bartlett JG, Goosby EP, Smith MD: Guidelines for the use of antiretroviral agents in HIV-infected adults and adolescents. Department of Health and Human Services, 1997.

6. Carpenter CCJ, Fischl MA, Hammer SM, et al.: Antiretroviral therapy for HIV infection in 1997: Updated recommendations of the International AIDS Society—USA Panel. *JAMA* 277:1962-1969, 1997.

7. Centers for Disease Control and Prevention: Update: Trends in AIDS incidence, deaths, and prevalence—United States, 1996. *MMWR* 46:165-173, 1997.

Dr. Paul, Mr. Triano-Davis, and Mr. Morgan are affiliated with the New Jersey Department of Health and Senior Services. Dr. Sensakovic is affiliated with Saint Michael's Medical Center. Dr. Podhurst is affiliated with the Division of AIDS Education, Center for Continuing Education in the Health Professionals, UMDNJ.



There's one thing better than being your own boss. Being your own landlord.

Finance Your Commercial Property With An SBA Loan from Valley National.

When you run your own business, you practically live there. So you may as well own the space. But there's one little problem. The size of the down-payment. That's why you need a Small Business Administration (SBA) Loan from Valley. It's a great way to build a nest egg for the future. We can provide up to 90% financing. And you can take up to 25 years to pay it back in affordable monthly payments. So, for about what you spend on rent, you can own your business space.

Because Valley National is a Preferred SBA lender, the approval process is amazingly quick. In most cases, initial credit approval takes three business days or less. And according to the U.S. Small Business Administration, you'll be working with the #1 SBA Lender in New Jersey for 1997. Our team of experts specializes in satisfying the needs of small businesses. Besides real estate, you can use an SBA Loan for working capital. And pay it back in up to 7 years. Or to buy equipment, and have up to 10 years to pay it back. So call us about an SBA Loan. It's quick. It's affordable. It's smart. And you'll actually like your landlord.

1-800-SBA-6772

Valley National Bank

Member Federal Reserve System. Member FDIC.

An Equal Opportunity Lender. Preferred SBA Lender.

THE BANK THAT WORKSSM

www.valleynationalbank.com

ROTHVALE RUTLEY OAKLAND DRADELL PARAMUS

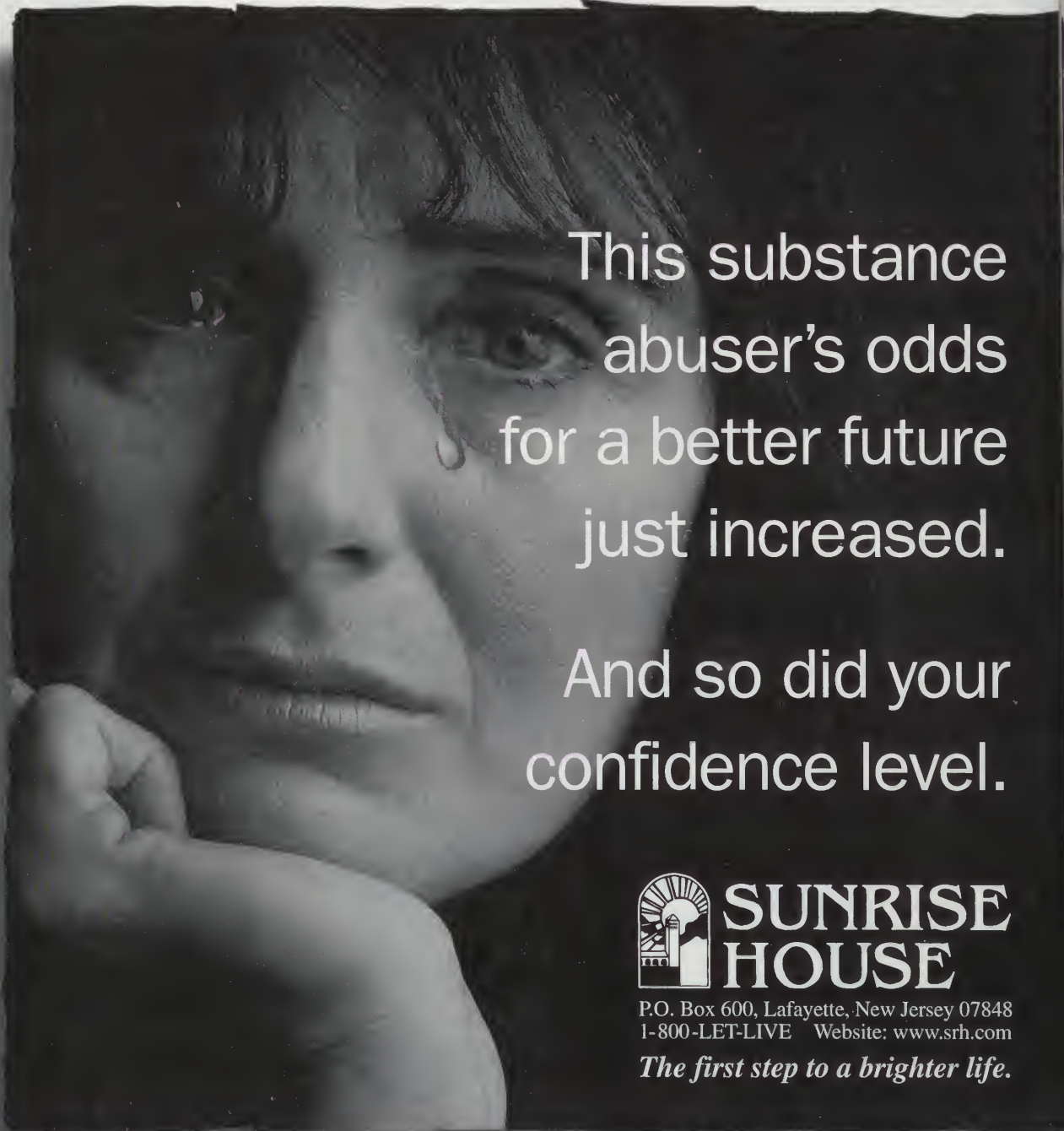
Whether it's an alcohol or drug problem, count on Sunrise House for expert help.

For 14 years, hundreds of tri-state area doctors have trusted us to offer their patients the most effective, caring treatment and a chance for a better life.

Set in the scenic hills of northwest New Jersey, we're a licensed, nonprofit specialty hospital with a nationally known commitment to quality—including Accreditation with Commendation by the JCAHO. Our comprehensive programs include inpatient and outpatient services, after-care and family support.

And our experienced staff of doctors and specialists works closely with referring physicians to ensure continuity of care at every stage of treatment.

Sunrise House. High-quality, affordable treatment you can trust. For information, call us at 1-800-LET-LIVE or (973) 383-6300.



This substance
abuser's odds
for a better future
just increased.

And so did your
confidence level.



**SUNRISE
HOUSE**

P.O. Box 600, Lafayette, New Jersey 07848
1-800-LET-LIVE Website: www.srh.com

The first step to a brighter life.

Sunrise House is a preferred provider of most major insurance companies and HMOs.
We will process insurance benefits verification and precertification.

RE-LEARNING THE WAY WE LEARN

HOW CAN PHYSICIANS AND OTHER HEALTH CARE PROFESSIONALS CONTINUE TO DO WHAT THEY DO BEST—CARE FOR PATIENTS? NEW JERSEY'S PHARMACEUTICAL COMPANIES ARE BRINGING HEALTH CARE PROFESSIONALS TO A HIGHER LEVEL THROUGH INNOVATIVE PROFESSIONAL EDUCATION PROGRAMS. THE RESULTS? A CLEAR AND CONVINCING SUCCESS.

The dramatic shifts in health care delivery that ushered in the last decade have gained new momentum as the state's providers brace themselves for practicing medicine in the new millennium. New Jersey's pharmaceutical and medical device companies have refocused their efforts to help ensure that physicians and other health care professionals have the best means to continue to do what they do best: care for patients.

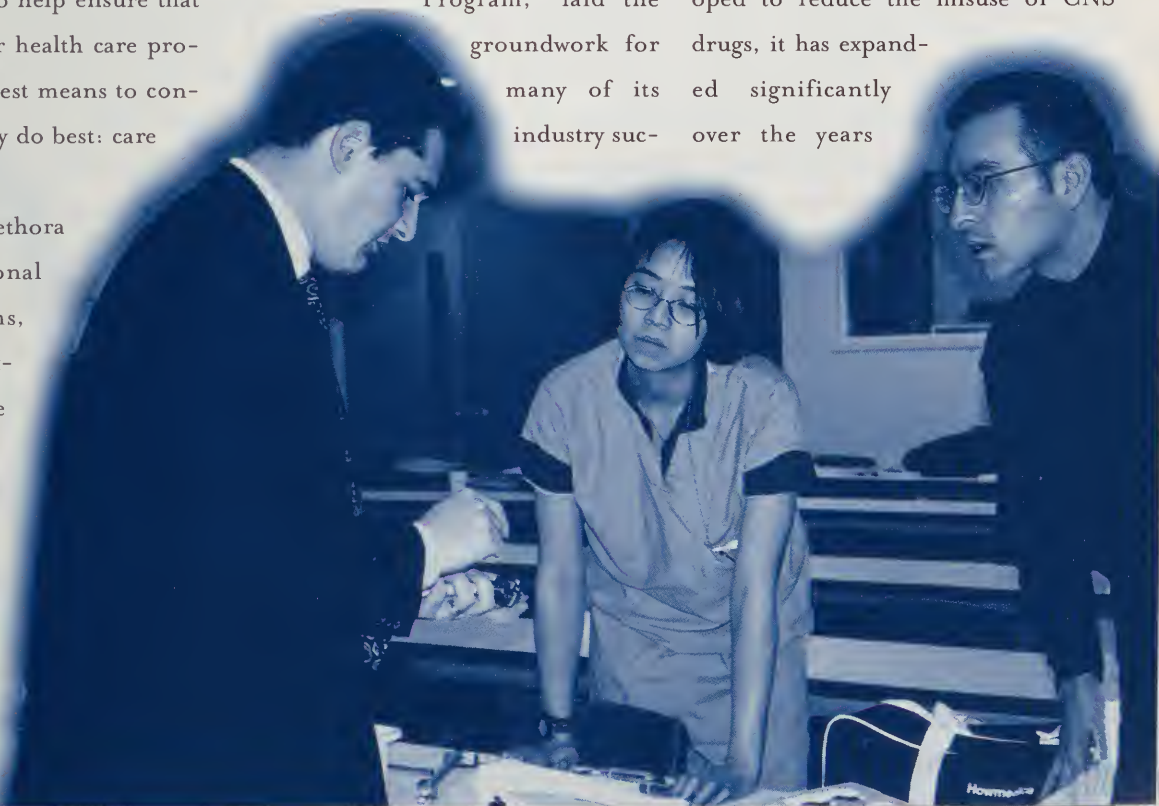
The result is a plethora of new professional education programs, consisting of a mixture of the more

conventional, along with offerings that encompass new delivery media, and others that focus on optimizing and measuring patient satisfaction with their health care experience in the doctor's office as well as the hospital.

One of the industry's oldest endeavors, Roche's "Medication Education Program," laid the groundwork for many of its industry suc-

cessors. "Since the program's introduction in 1977, Roche has distributed more than 60 million brochures to physicians to help them enhance dialogue with their patients on health care issues," says Vince Mattiliano, medical affairs manager, Roche Laboratories. While the program was initially developed to reduce the misuse of CNS drugs, it has expanded significantly over the years

Aldo Denti, Worldwide Group Product Manager/ External Fixation, demonstrates the Hoffman® II Compact Fixator to residents at the Howmedica Inaugural Resident Fracture Fixation Course.



and now contains information on several classes of drugs and pharmaceutical issues, as well as bilingual editions and coloring books for children.

Another long-standing program is Novartis' support for the publication of *Netter Collection of Medical Illustrations*, from which the company has derived *Interactive Atlas of Clinical Anatomy*, published on CD-ROM.

Other companies have focused more closely on providing resources in the therapeutic areas they know best. For example, Becton Dickinson produces "Getting Started," a program to assist physicians and health educators in initiating insulin therapy among newly diagnosed patients, and a "Staged Diabetes Management Program" that provides clinical pathways to help manage patients from their diagnosis through treatment.

According to Bob Briggs, executive vice-president of the American Diabetes Association of New Jersey, "For over a decade, Becton Dickinson has partnered with us on programs that raise awareness of diabetes,

and also help patients maintain optimal control over their medication."

Hoechst Marion Roussel takes a similar approach, but with a new twist: "home" delivery. In conjunction with The Academy of Medicine of New Jersey and the New Jersey chapter of the Arthritis Foundation, Hoechst has developed a "roving symposium" series on osteoarthritis and rheumatoid arthritis.

"The continuing medical education (CME) program is being offered statewide to 15 New Jersey hospitals beginning later this year to help primary care physicians better understand, diagnose, and treat arthritis, as well as make referrals to specialty care," explains Dennis Hirschfelder, Arthritis Foundation of New Jersey president.

At Howmedica, a Pfizer division headquartered in Rutherford, three nurses and a physician assistant are on staff "to improve patient care

and outcomes through education," according to Don Campeau, worldwide director of training and education. This leading manufacturer of orthopedic implants and bone cement, which offers national and regional symposia, self-study guides with continuing education credits, and on-site reconstructive learning centers, estimates that more than 2,000 health care professionals participated in company-supported educational programs last year alone.

Combining education and entertainment, Princeton-based Nycomed Amersham Imaging recently introduced a CME-accredited computer "game" designed to help radiologists and radiology fellows enhance their practice skills while earning CME credit. Called "Rad Rounds," the program contains two freestanding CD-ROM programs, available in Mac and Windows® formats, which are designed "to trans-

form users from passive recipients to active participants in the learning process."


A New Jersey company known for its women's health care products—most notably, the birth control pill—has gone beyond medical education to provide programs with a social focus. For five years, Ortho-McNeil has offered the

Becton Dickinson has developed diabetes education programs.



"Issues in Women's Health" series, which consists of several CME-accredited programs that train health professionals in dealing with some of the most sensitive obstetrical-gynecological issues. The series includes training in detecting sexual abuse in children, conducting a medical-legal examination of a rape victim, responding to victims of domestic abuse, and gynecology issues in mentally retarded and physically disabled patients.

"Our newest program assists practitioners in managing the emotional side effects of pre-term labor, a condition that is on the rise with an increase in the number of older women giving birth, and multiple births due to in vitro fertilization," says Diana Frost, Ortho-McNeil manager of medical education.

ther industry programs provide tools to help medical professionals from New Jersey and across the nation enhance their practice management skills in new health care delivery systems. Among these include Novartis' "Words Well Spoken," a training program to help

**INDUSTRY PROGRAMS
PROVIDE TOOLS TO HELP
MEDICAL PROFESSIONALS
ENHANCE THEIR PRACTICE
MANAGEMENT SKILLS IN
NEW HEALTH CARE
DELIVERY SYSTEMS.**

physicians improve communications with patients.

The company also offers the "Virtual Information Network," a password-protected web site that offers health care news on a daily basis, *The Novartis Report on Member Satisfaction*, which tells physicians how satisfied patients are with their primary care providers, and *Pharmacy Benefit Report*, which provides pharmacy benefit managers with regional and national data.

The company also offers managed care symposia for cross-functional teams within health care systems. "Their symposium on information systems helps members visualize the obstacles each other is up against," notes participant Darlene Mednick, RPh, vice-president of product development and project management at Merck-Medco in Montvale. "It became quite clear that we could not assess the quality of care if we didn't have the right information."

Bracco Diagnostics, Inc. has applied similar principles to the field of radiology. Its Patients' Assessment of Satisfaction Services (PASS) program enlists the technical support of the largest hospital market research firm in the country to enable institutions to administer a followup questionnaire to every patient who utilizes its radiology services. Results are provided to the hospitals, which can use the benchmarking information to improve their services.

The Princeton-based company also offers on-site radiology coding and reimbursement consulting services, which "help us to keep current on CPT codes and reimbursement issues that impact our diagnostic and interventional procedures," says Judy Lewis, administrative director for cardiac services at Hackensack Medical Center.

In addition to these programs, the state's health care companies also support a wide range of clinical grants and residency and fellowship programs that are helping to lay the groundwork for the future of health care delivery. One of these, the Bristol-Myers Squibb Unrestricted Biomedical Research Grants Program, has provided nearly \$70 million to more than 145 academic institutions worldwide since its inception in 1977.



All The Doctors...

Who Use Us For Accounts Management

**Found Us To Be Invaluable
in Safeguarding Their Income**

- H.M.O. Claims Verified and Finalized
- Compensation and No-Fault Cases Settled
- Patient Balances and Self-Pay Accounts Collected

Cut Office Costs

Eliminate:

- In-House Collection Expense
- Your Office Staff's Endless Hours on the Phone with Insurance Companies
- The Constant Follow-Up With Patients That Promise to Pay Balances

To Get More Information About Our Company Call:

Client Contact Company

1(800) 645-2303

E-mail: MedmanCo@AOL.com • FAX 1(800) 473-1184
2949 Long Beach Rd., Oceanside, N.Y. 11572

Practical Issues in Cancer Genetics

Thursday, May 28, 1998

Princeton Marriott Forrester Village
Princeton, NJ

8:00 a.m.-5:00 p.m.

Featured Faculty

- Daniel Burk, JSM, JD, Seton Hall University
Charis Eng, MD, PhD, Dana Farber Cancer Institute
Judy Garber, MD, Dana Farber Cancer Institute
Monica Magee, MS, UMDNJ-Robert Wood
Johnson Medical School
Kenneth Offit, MD, Memorial Sloan Kettering Cancer Center
T.S. Ravikumar, MD, The Cancer Institute of New Jersey
Amy Strauss Tranin, RN, MS, OCN,
The Cancer Institute of Health Midwest
Deborah Toppmeyer, MD, The Cancer Institute of New Jersey

Sponsored by

American Society of Clinical Oncology
The Cancer Institute of New Jersey
The New Jersey State Commission on Cancer Research
and the Oncology Society of New Jersey

For more information call:

(732) 235-6786 or (609) 633-6552

Balancing Quality With the Bottom Line

Practicing medicine
= good

Practicing running
a business
≠ good

*Practice management and
practice efficiency solutions
from professionals with
hands-on experience*

WITHUM, SMITH & BROWN

Certified Public Accountants & Consultants

Health Services Department

100 Overlook Center

Princeton, NJ 08540

609-520-1188

<http://www.withum.com>

Offices in New Jersey and Pennsylvania



ATAO Accounting for Time,
Activity and Cost

MEMBER NEXIA INTERNATIONAL
A WORLDWIDE NETWORK OF
INDEPENDENT ACCOUNTING FIRMS



DISPENSING THE CURE from the PHARMACY

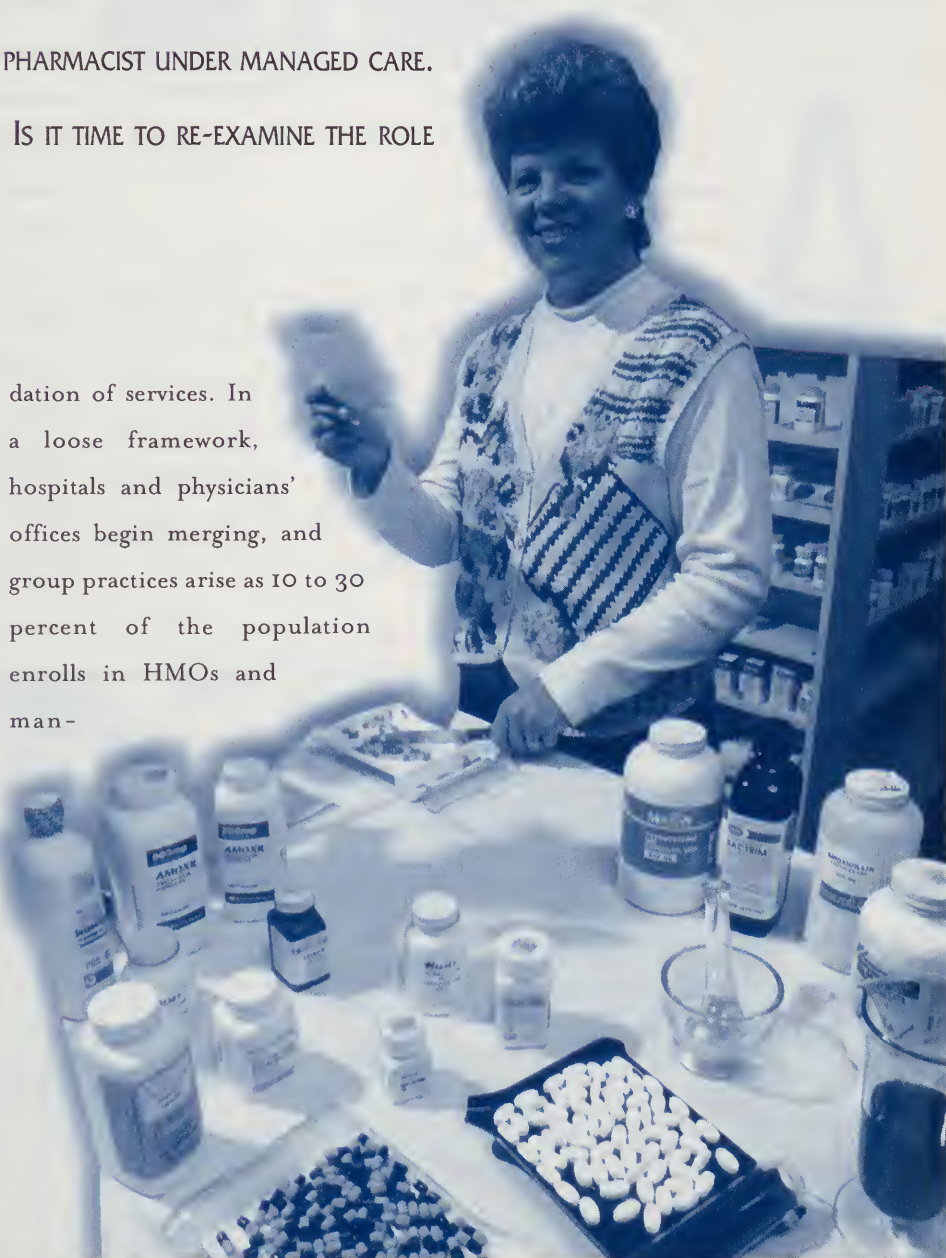
CONSOLIDATION IN PHARMACY IS GROWING. SURVIVE AND THRIVE IS THE
NAME OF THE GAME FOR TODAY'S PHARMACIST UNDER MANAGED CARE.
BUT MORE CHANGE IS IN THE AIR. IS IT TIME TO RE-EXAMINE THE ROLE
OF THE PHARMACIST?

Gregg Lubinsky, RPh, CCP

Consolidation by large managed care organizations is dictating the way pharmacists practice. Many managed care organizations believe that cost containment can be achieved by restricting the drug choice of health care practitioners and patients. Programs that emphasize cost and financial incentives at the expense of patient rights and optimal patient outcomes can create multiple problems.

In an unstructured marketplace, less than 10 percent of the population is enrolled in an HMO or managed care plan, and there is little or no consoli-

dation of services. In a loose framework, hospitals and physicians' offices begin merging, and group practices arise as 10 to 30 percent of the population enrolls in HMOs and man-



aged care. Next, a rapid consolidation occurs where 30 to 50 percent of the population is enrolled in managed care. Managed competition occurs when more than 50 percent of the population is enrolled in managed care. Cost versus quality of care issues begin to chase each other. Organizations lower costs to be competitive and then attempt to increase quality at a given cost in a continuing cycle.

As the market changes, several parameters in the evolution process illustrate the pressures on pharmacists. Current estimates indicate that 25,000 retail outlets are needed in the nation to provide prescriptions across the country. In the U.S. there now are approximately 50,000 stores. As consolidation in pharmacy continues, this number will continue to shrink.

Mergers will further tighten the market. Five years ago, no single pharmaceutical company had more than 5 percent of the market. Now eight or nine companies have 50 percent of the market. As this trend continues, three or four managed care pharmacy companies will have 80 percent of the market in any geographical area. They will be competing in terms of cost, quality, price, and competition. This will impact negatively on pharmacists' decision making and internal drug distribution systems.

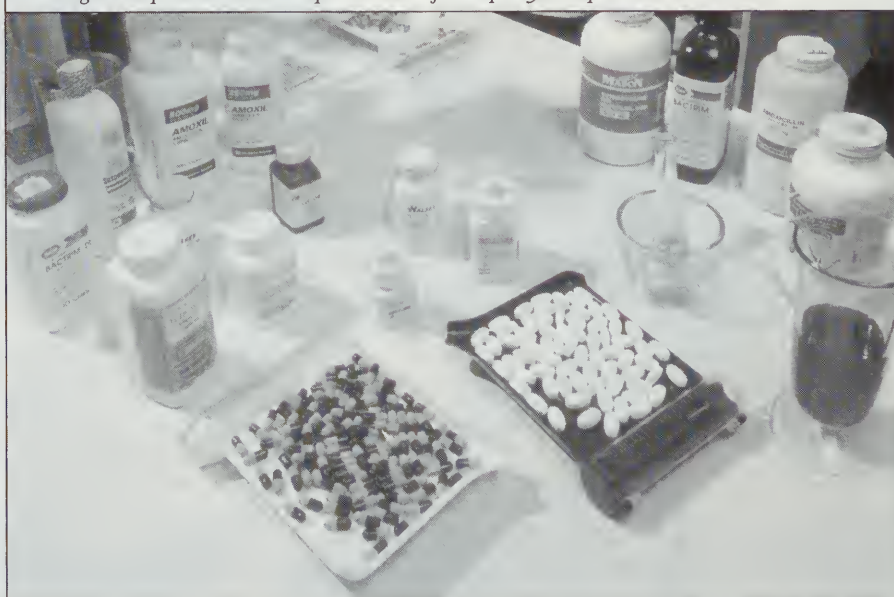
Additionally, an increase in mail order prescriptions is threatening the ambulatory care pharmacy market. Currently, approximately 15 to 20 percent of prescriptions are processed by mail; that number is expected to grow to 40 to 50 percent by the year 2001.

Taken together, trends toward consolidation and the omission of retail sales point to a tightening of the pharmacist's market and these are the biggest threats to ambulatory care pharmacists today. Competition will increase as pharmacists try to survive the changes in the marketplace. Individual pharmacists will have to develop their professional skills and partner with other colleagues' skills and resources to maintain and grow their business.

In addition to pressures from the marketplace, legislative and regulatory changes are reforming the face of health care. National legislation aims to cut spending across the board in health care. Skilled nursing facilities (SNF) may be hardest hit. The Balanced Budget Act of 1997 will cut over \$9 billion from the Medicare SNF program over the next five years.

The current annual expenditures for Medicare SNF care is approximately \$11 billion. For pharmacists to absorb a significant part of this hit without compromising quality care

Managed care pharmacies will compete in terms of cost, quality, and price.



will be challenging. To survive and thrive, pharmacists must re-examine how all ancillary services, including the dispensing functions, are provided.

Familiar debates on the future of social security, changing Medicare and Medicaid benefits, and the struggles of living on a fixed income reveal that society will be forced to address its aging population on many levels. For the entire health care industry, including pharmacists, the implications and issues in the "graying of America," are clear. We must excel at serving a 50-plus population. To do so, pharmacists must be adequately compensated for their clinical expertise. Tracking the growing number of seniors, understanding their needs, and responding with appropriate care and services is vital to pharmacists success with this population.

We all recognize that drug cost-containment efforts by managed care organizations include formularies. Pharmacists often are under tremendous pressure to increase generic substitution, but it is important that pharmacists not make hasty decisions regarding generic substitution.



Gregg Lubinsky, RPh, CCP

Drug product substitution can take the form of generic substitution or therapeutic substitution. In the great majority of cases, a generic or therapeutic substitution will be completely appropriate and not result in any adverse consequences for the patient. Some situations have higher risks than others, and require a higher degree of professional scrutiny.

Drugs with narrow therapeutic windows such as digoxin, warfarin sodium, and theophylline fall into this category. Where a patient has been stabilized on a particular drug product that fits into the above category, substituting a generic equivalent could result in blood level variations significant enough to affect safety and efficacy.

What should the pharmacist do? The appropriate standard of care in

such instances would seem to require that a substitution not be made without the consent of both the prescriber and the patient after they have been specifically advised of the bioequivalency issue and attendant risks by the pharmacist. Simply restricting the patient to the least expensive generic drug or therapeutic alternative might present clinical problems in patients.

Aside from dispensing medications, pharmacists already are offering pharmaceutical care, which may be the primary care system for many patients. Managed care should look to pharmacists to help coordinate team services and track outcomes and cost savings.

No longer is it acceptable for the pharmacist to merely ensure that the right drug is dispensed to the right patient in the right amount and dosage with the right directions. The practice of pharmacy has shifted from a product-oriented service to a patient-oriented profession. As a result, managed care organizations need to recognize that pharmaceutical care is a cognitive service.

Mr. Lubinsky is pharmacy consultant coordinator for Correctional Medical Services, Mt. Laurel, and serves on the Review Board for New Jersey Medicine.

She had a heart operation when she was seven. Now she's a physician herself, helping save lives every day.



Doctors don't just happen. There is a story behind every doctor's oath to heal the sick and ease the pain. Whatever that story is, we're reminded that the best-trained physicians in the world are right here.

 **NOVARTIS**

WE'RE IN IT FOR LIFE.

 ©1998 Novartis Pharmaceuticals Corporation LY064

NEW JERSEY RESIDENTS: DOUBLE-TAX-FREE INCOME

100% NO LOAD

**YIELDS
7.20%**

Tax-equivalent
36% tax rate

4.31%

Current
30-day yield
as of 3/22/98

T. Rowe Price New Jersey Tax-Free Bond Fund is ranked #2 out of 16 funds in the Lipper New Jersey Municipal Debt Category since its inception (4/30/91) for the period ending 3/31/98.* This fund invests primarily in long-term New Jersey municipal securities, so the income it offers is double-tax-free. *You pay no state or federal tax on your investment earnings.*** Proprietary credit analysis and active management help reduce risk. Of course, the fund's yield and share price will fluctuate as interest rates change.

With no sales charges, all your money works for you. The fund is 100% no load. And, since there are no broker fees—which can eat up as much as 5% of your principal—all your money gets invested. \$2,500 minimum. Free checkwriting.†



**Call 24 hours for a
free report and prospectus**

1-800-541-4624

www.troweprice.com

Invest With Confidence®
T. Rowe Price 

10.64%, 6.46%, and 7.90% are the fund's 1-year, 5-year, and since inception (4/30/91) average annual total returns, respectively, for the periods ended 3/31/98. Fig include changes in principal value, reinvested dividends, and capital gain distributions. Investment return and principal value will vary, and shares may be worth more or less than at original purchase. *According to Lipper Analytical Services, Inc., which ranked T. Rowe Price New Jersey Tax-Free Bond Fund #10 out of 57 for the 1-year period ended 3/31/98. **Some income may be subject to the federal alternative minimum tax. Income earned by non-New Jersey residents will be subject to applicable state and local taxes. †\$500 minimum. Past performance cannot guarantee future results. Read the prospectus carefully before investing. T. Rowe Price Investment Services, Inc., Distributor. NJB04

DOLLARS & SENSE OF THE HEALTH CARE INDUSTRY

THEY ARE AN \$8 BILLION INDUSTRY. THEY ARE IN 16 OF THE 21 COUNTIES, WITH 115 LOCATIONS. THEY COVER OVER 84,000 ACRES. THEY ARE NEW JERSEY PHARMACEUTICAL AND MEDICAL DEVICE COMPANIES AND THEY HAVE MADE THE GARDEN STATE INTO THE MEDICINE CHEST OF THE NATION. THE IMPACT OF THESE COMPANIES GOES BEYOND THE BORDERS OF OUR STATE.

by William H. Tremayne

It is the mission of the HealthCare Institute of New Jersey (HINJ) to raise awareness, understanding, and public support for the research-based pharmaceutical industry and related health care businesses among New Jersey's elected and appointed officials, media, citizens, and health care leaders. Last year,

HINJ studied its member companies to survey the impact of the pharmaceutical industry on New Jersey. The results of this economic impact study by Coopers & Lybrand offer a telling picture of the state of the pharmaceutical and medical device industry. Taking credit for 17 of the 48 significant new drugs

in 1997 is evidence of the national and world role New Jersey pharmaceutical companies play in the health care arena today.

More than 60,000 women and men travel every day to pharmaceutical companies around the state. They are

In Bridgewater, the new Global Development Center for Hoechst Marion Roussel.



scientists, researchers, sales personnel, administrators, support personnel, and executives. With more than 115 locations in 70 different municipalities in 16 of the 21 counties, these locations cover more than 84,000 acres with a property tax assessment of over \$2.6 billion.

These facts have not been lost on the state's political establishment. Governor Whitman recognized the birth of HINJ last year by joining industry leaders for "Pharmaceutical Research Day" in Trenton. Whitman noted, "New Jersey's status and the medicine chest of the world was not earned overnight. I believe it's vital for state government and the pharmaceutical and medical device industry to work together to maintain a favorable climate. Its employees and its emphasis on science and research go to the heart of two important initiatives of the administration—a diverse economy and excellence in education."

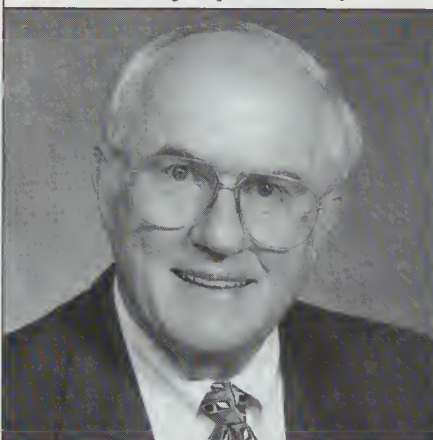
State Senator Donald DiFrancesco added, "My district is home to many of these employees. The com-

panies and their employees are an economic presence, but even more importantly, a strong civic presence. They have been the important architects of the New Jersey we know today, and I know will be for many years. Their worldwide leadership in health care can only enhance our state's reputation as a national economic leader."

Nearly one-third of the state's pharmaceutical and medical device industry employees are involved in the research and drug development sector; a portion of the workforce that has grown, and will continue to grow through commitments such as:

- Completion of Hoechst Marion Roussel's Global Development Center in Bridgewater, with 1,050 employees.
- Progress of Merck & Company's new research facility in Rahway, measuring 332,999 square

William H. Tremayne, president, HINJ



feet to house 325 leading scientists upon completion in 2000.

- Progress of Bristol-Myers Squibb's development of a new research campus in Hopewell for 2,000 new employees.
- Growth of Knoll Pharmaceutical Company additions to its Mount Olive campus.
- Novartis, Schering-Plough, and Hoffmann-La Roche have completed new capital commitments to research and development.
- Pharmacia & Upjohn's relocation to Bridgewater Township.
- Nycomed Amersham Imaging's relocation to Princeton.

The pharmaceutical industry's capital commitments compare favorably with other industrial sectors. According to the New Jersey Alliance for Actions' annual construction forecast for last year, \$7.8 billion worth of public and private sector construction activity was forecast, and the industry's figure of capital expenditures is a significant contribution. The expenditures are slightly less than that of the Department of Transportation (\$850 million) and more than that of the Port Authority of New York and New Jersey (\$600 million).

Just slightly behind the capital expenditures is \$740 million expended for contracted services, which is emblematic of the industry's trickle down effect. Many New Jersey businesses, primarily smaller ones, owe their livelihood to the presence of the pharmaceutical and medical device industry.

Such can be said for the Garden State's advertising industry, which has thrived on work in the field. One example of this massive expansion of the industry's advertising to the public and private sectors is shown through Integrated Communications of Parsippany, which now is among the top five of all advertising agencies in the state, with over \$200 million in revenue from the pharmaceutical industry. Jeff Rich, chief creative officer, states, "A record number of products was approved by the FDA in 1997 and New Jersey is rapidly becoming the center for the health care communications industry."

The industry also is a major player in civic and philanthropic causes,



William R. Healey, vice-president, HINJ

evidenced by over \$40 million worth of annual contributions. One such project was the Community Theatre

of Morristown, which received a grant of \$250,000. The state Capital Dome Project has received a major donation from Bristol-Myers Squibb, Johnson & Johnson, and Hoffmann-La Roche.

The economic activity of the pharmaceutical and medical device industry is \$8 billion, equal to one-half of the state of New Jersey's annual budget. The medicine chest of the nation is a big driver in the economic engine of New Jersey. ■

How the pharmaceutical and medical device industry affects New Jersey's economy.

- \$3.2 billion in employee wages
- \$1.27 billion in value of shipments
- \$750 million in capital expenditures
- \$740 million in contracted services
- \$640 million in manufacturing and vendor supplies
- \$610 million in employee and retiree benefits
- \$330 million in utility and rentals/leases
- \$200 million paid in state and local taxes
- \$160 million in industry-run indigent drug programs and samples
- \$40 million in Medicaid and PAAD rebates
- \$40 million in charitable contributions
- \$30 million in other employee income [401K]

Source: Coopers & Lybrand

Only MIIX offers



the Toolkit that fits in your briefcase.

Provided by MIIX Financial Services

The MIIX Toolkit, designed specifically for physicians, explains how you can access:

- **MIIX Buying Service** — offering discounts up to 70% on quality medical and office supplies and equipment.
- **Equipment Leasing** — equipment lease financing and lines of credit at competitive rates.
- **Receivables Management** — providing collection of medical accounts receivable.

To find out more about this powerful resource,
call MIIX Financial Services at

1-800-227-MIIX.

Endorsed by the

Medical Society of New Jersey

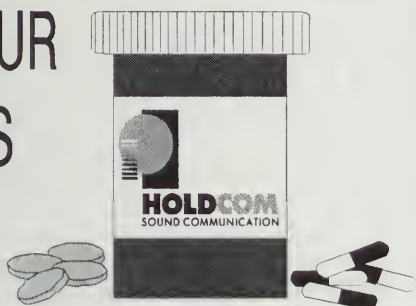
MSNJ

MEDICAL INTER-INSURANCE EXCHANGE

POWERFUL PARTNERSHIPS



THE RIGHT PRESCRIPTION FOR YOUR CALLERS



Message-On-Hold Systems

Use your telephone music-on-hold feature to:

- Promote Services
- Reassure Callers
- Educate & Inform
- Encourage Referrals

HOLDCOM

Serving the NJ Healthcare Industry Since 1987

Call 1-800-666-6465

<http://www.holdcom.com>

EMERGENCY PHYSICIANS

Emergency Physician Associates, a Team Health affiliate, is seeking quality ED physicians for a variety of practice opportunities in NJ, PA, MD, NC and NY.

We offer physicians competitive compensation, flexible schedules, malpractice insurance, a variety of practice settings, and supportive Medical Directors.

Interested candidates may call

1-800-848-EPA-1.

Specializing in the Business of Health Care

Physician Practice Assessment/Contract Negotiations
Fee Schedule & Super Bill Analysis/New Practice Set-Up
Coding Issues/Risk Management

Call Evelyn Gross, CMM, CPC
(201) 261-4030

HUNTER HEALTHCARE SERVICES

Division of RD Hunter & Company LLP
Paramus, NJ New York City



Druker, Rahl & Fein

Business Consultants
Certified Public Accountants

We have your prescription to profitability

We're Druker, Rahl and Fein, the accountants and advisors
to physicians and health care providers.

...Managed Care..Government Regulations

..the industry is changing..quickly.

How will these changes affect your practice?

You have questions and you need answers.

Our medical services experts will assist you
in developing a strategy to

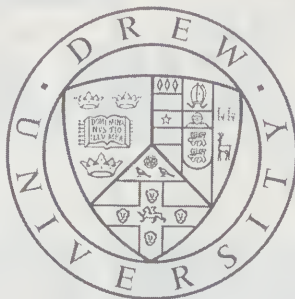
succeed in this dynamic environment.

Leaders in:

Cost Accounting • Strategic Planning • Group Practice Formation • Tax
Managed Care Analysis • Practice Valuations • Practice Management

200 Canal Pointe Boulevard • Princeton, NJ 08540-5998 • 609-243-9700 • FAX 609-243-9799

Contact Robert J. Rahl, CPA



The Faculty, Staff, Deans and Students of the Graduate
School of Drew University

wish to congratulate

Colleen Holland of Woodbridge, NJ

Jeanne Kerwin of Whitehouse Station, NJ

Jean Anne Nix of Jackson, NJ

as the initial recipients of the degree

**Master
of
Medical Humanities**

on May 23, 1998

This program, which is designed to foster interdisciplinary work in bio-medical ethics, medical narrative, medicine and the arts, the history of medicine, and related fields, has grown from 3 students to over 30 in just 2.5 years.

We are extremely proud of our initial master's degree graduates whom we are confident will make important contributions to the health care field.

*For more information about Drew's program
in the Medical Humanities, please call 973/408-3110.*

The Medical Society of New Jersey would like to congratulate the physicians awarded the 1998 Golden Merit Award. These members are honored for holding the degree of doctor of medicine for 50 years.

ATLANTIC COUNTY

Walter T. Bew, Jr, MD
Tennessee '48
Frederick G. Panico, MD
Pennsylvania '48

BERGEN COUNTY

Lawrence E. Batlan, MD
Chicago Medical '48
Anna M. Burton, MD
NY Medical '48
Marc J. Crilly, MD
Georgetown '48
Lawrence Joshua Denson, MD
NY University '48
Maurice F. Deraney, MD
Beirut '48
Maurice Golbey, MD
Long Island '48
Harold R. Hanson, MD
Boston '48
Richard W. Holeman, MD
George Washington '48
Murray Kahn, MD
Jefferson '48
David E. Landers, MD
Georgetown '48
Elias Lika, MD
Bologna '48
Dermot B. O'Herlihy, MD
Ireland '48
Robert J. Oehrig, MD
Cornell '48

Kathleen E. Shanahan-Cohen, MD
George Washington '48
William Carlton Soule, MD
Harvard '48
Konstantin P. Velis, MD
Beirut '48

BURLINGTON COUNTY

Conrad Malcolm Brahlin, MD
Hahnemann '48

CAMDEN COUNTY

Richard Crompton Goos, MD
Hahnemann '48
Herbert Morton Marks, MD
Edinburgh '48
Ben Poliakoff, MD
South Carolina '48
John Randolph Rushton, III, MD
Jefferson '48

ESSEX COUNTY

Mervin Leonard Binder, MD
Marquette '48
Arthur Samuel Bogart, MD
Marquette '48
Jerome A. Cantor, MD
NY University '48
Nazar Y. Davidian, MD
Beirut '48
Robert Karl Egge, MD
NY Medical '48
Stanley Samuel Fieber, MD
Vermont '48
William Forte, MD
Naples '48
Ingeborg Schraft Hoffman, MD
University Munich '48
Domenic G. Iezzoni, MD
Columbia '48

William B. Kantor, MD
NY Medical '48
Aaron N. Kaplan, MD
Wisconsin '48
Joseph Francis Lutz, MD
Georgetown '48
Donald J. Mac Pherson, MD
Vermont '48
Joseph Puleo, MD
Palermo '48
Benjamin F. Rush, Jr, MD
Yale '48
Carl John Schopfer, MD
Temple '48
Bohdan Osyp Shebunchak, MD
Erlangen '48
John Joseph Siudmak, MD
NY Medical '48
Joseph William Tafaro, MD
Loyola '48
Wilber Frederick Taylor, MD
Hahnemann '48
Lester Weissman, MD
Illinois '48

GLOUCESTER COUNTY

Rudolph Theodore De Persia, MD
Jefferson '48
Thomas Francis Flynn, Jr, MD
Hahnemann '48
Faith C. Walsh, MD
Pennsylvania '48

HUDSON COUNTY

Alexander Cataldo, MD
Naples '48
Eugenia Karvouni Flessas, MD
Athens '48

Janet Geraghty-Deutsch, MD

Long Island '48

Giuseppe Mauriello, MD

Naples '48

Raymond Edward Pennie, MD

NY Medical '48

Carl Aurel Restivo, Sr, MD

Hahnemann '48

HUNTERDON COUNTY

Robert R. Henderson, MD

NY University '48

Harry M. Woske, MD

Long Island '48

MERCER COUNTY

Josephine C. De Francesco, MD

Temple '48

Howard Leonard Levenson, MD

Hahnemann '48

Jorge Mora, MD

Columbia '48

Miriam C. Reed, MD

Women's Medical '48

Benjamin K. Silverman, MD

Maryland '48

Frederick Matthew Spitzhoff, MD

NY Medical '48

MIDDLESEX COUNTY

Severin Thomas Golojuch, MD

NY University '48

Le Roy Homer, MD

Pennsylvania '48

John James Kangos, MD

Long Island '48

Samuel H. Silverman, MD

Long Island '48

Jasper L. Van Avery, Jr, MD

Buffalo '48

Robert J. Zullo, MD

Harvard '48

MONMOUTH COUNTY

Joseph Reed Ackerman, MD

NY Medical '48

M. Leonard Genova, MD

Albany '48

William Alfred Herbert, MD

Indiana '48

Timothy Patrick Lee, MD

Ireland '48

MORRIS COUNTY

John Joseph De Laney, MD

Pennsylvania '48

Orr J. Elder, MD

Columbia '48

Clement Augustine Furey, Jr, MD

Western Reserve '48

Lee W. Geller, MD

Indiana '48

Andrew G. Hudacek, MD

Georgetown '48

Henry Robert Liss, MD

Jefferson '48

Nelson H. Schimmel, MD

Jefferson '48

Byron Grant Sherman, Jr, MD

NY University '48

OCEAN COUNTY

James Francis Dougherty, MD

Rochester '48

PASSAIC COUNTY

H. Louis Chodosh, MD

NY University '48

Seymour Nochimson, MD

NY Medical '48

SOMERSET COUNTY

Albert Mark Doswald, MD

Zurich '48

Chi Hao Edwin Lee, MD

St. Johns China '48

SUSSEX COUNTY

John C. Lucas, Jr, MD

George Washington '48

UNION COUNTY

William F. Bauer, MD

Heidelberg '48

Anthony Michael Bebbino, MD

Indiana '48

Hans R. Bloink, MD

Long Island '48

James Leroy Brady, MD

Rochester '48

Paul Lowell Chodosh, MD

Virginia '48

Alice E. Drumm, MD

Temple '48

William Eugene Ganss, MD

NY University '48

Michael J. Huk, MD

Heidelberg '48

Frank Fremont Kaiser, Jr, MD

NY University '48

Edmond R. Kassouf, MD

NY University '48

Herbert Langer, MD

Arkansas '48

Robert Bruce Milligan, MD

Temple '48

Gloria Ogur Schrager, MD

Women's Medical '48

Alvin Stanley Schwartz, MD

NY University '48

Anthony Michael Spirito, MD

Pennsylvania '48

Richard Wirt Taylor, MD

Illinois '48

Harry M. Zutz, MD

Jefferson '48

WARREN COUNTY

Stanton Henry Sykes, MD

Temple '48

Our medical specialists make a practice of creating solutions for physicians like you.

Summit Bank's Healthcare Financial Services Group features some of the finest medical specialists in New Jersey. They understand your industry and the issues facing it. As New Jersey's largest locally headquartered bank, our professionals are specifically devoted to the healthcare industry. That means our customized solutions — from loans to leases — come with something extra: time-tested expertise. If you'd like, we'll even help you find a more efficient way to run your practice. To find out more, call Norm Buttaci, Regional Vice President, 609-987-3561.



Reach Higher
SUMMIT
BANK

Summit, Summit Bancorp and Reach Higher are registered service marks of Summit Bancorp • Summit Bank is a service mark of Summit Bancorp.

Editorial Guidelines

Editorial Guidelines

The principal aim in the preparation of a contribution should be relevance to health care and to the education of health care professionals. The contents of each issue include an important health care development; an indepth interview highlighting a health care newsmaker; an update on a key public health issue; a peer-reviewed clinical report; brief highlights of the latest events and findings in the health care industry; and a monthly forum for readers. Proposals for special submissions will be considered on an individual basis. Letters to the editor are welcome and will be edited and published as space permits. Notices of events, programs, and meetings are encouraged.

Copyright

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or separate statement accompanying material offered to *New Jersey Medicine* must contain the following language, and must be signed by all authors.

"In consideration of *New Jersey Medicine* taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey in the event that such work is published in *New Jersey Medicine*."

Publication Policy

New Jersey Medicine will review original unpublished materials on topics relevant to health care professionals in New Jersey. All submissions are subject to peer review and are edited to conform to the style of *New Jersey Medicine*. Receipt of materials will be acknowledged. Final decision is reserved for the editor. No direct contact between the reviewers and the

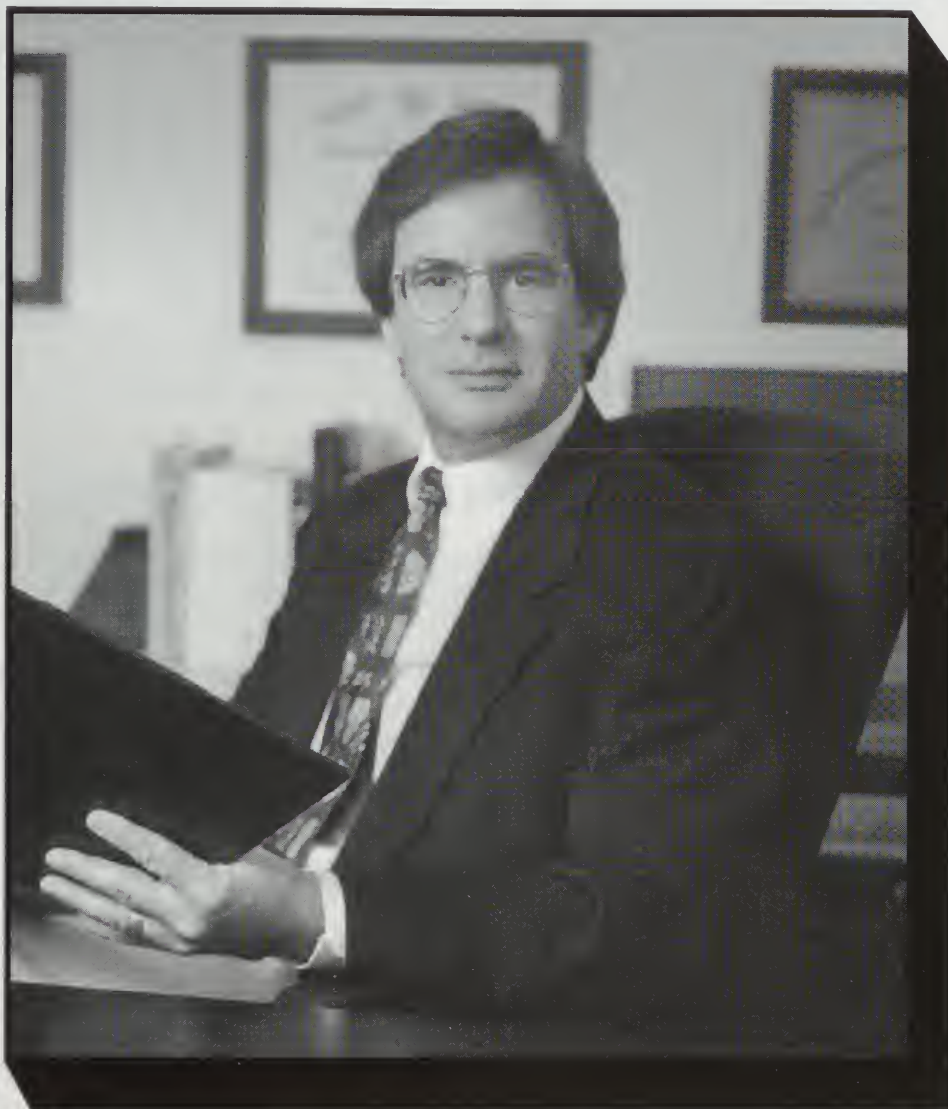
authors will be permitted. Upon acceptance, authors will have the opportunity to review edited material. All communications should be sent to *New Jersey Medicine*, Two Princess Road, Lawrenceville NJ 08648.

Specifications

Materials compatible with Microsoft Word 97 for Windows should be submitted on diskette (3 1/2 inch), and should be accompanied by a printed copy of the material, a cover letter identifying the submission, and a copyright form.

The title page should include the full names, degrees, and affiliations of all authors, and the name and address of the author to whom correspondence should be sent.

The author(s) should submit a 50-word abstract to be used at the beginning of the article. References should not exceed 20 citations and should be cited consecutively by superscripted numbers at the end of the sentence. The style of *New Jersey Medicine* is that of *Index Medicus*: 1. Goldwyn RM: Subcutaneous mastectomy. *NJ Med* 74:1050-1052, 1977. Tables and graphs should be presented at the end of the article. Illustrations should be of professional quality, black and white glossy prints. The name of the author, figure number, and top of the figure should be clearly marked on the back of each illustration. When photographs of patients are used, the subjects should not be identifiable or publication permission signed by the subject or responsible person must be included. Materials taken from other publications must give credit to the original source. Generic names should be used with proprietary names indicated parenthetically with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol.



Stuart M. Hochron, M.D., Esq.

Physician Legal Representation

- Group Practice Formation
- Physician Litigation
- Federal Regulation
- Board of Medical Examiners

Practicing Physician, Twenty Years

Clinical Professor, UMDNJ-RWJMS

Research as Highlighted on CNN

AMA Physician Referral Service

Partner, Richmond, Hochron & Burns



phone: (732) 821-0200 fax: (732) 422-9444 e-mail: MDLAWSMH@aol.com

209 North Center Drive North Brunswick, New Jersey 08902

Here's what we are covering in June 1998

⇒ What is the health impact of today's eating disorders?

Medical writer Robin Rapport details why eating disorders are hard to diagnose and even harder to treat, and how the medical community needs to deal with the increase of this disorder.

⇒ What are the challenges facing graduate medical education?

Two main forces have driven graduate medical education to the forefront: future physician workforce requirements and financing for GME. This article looks at where GME in New Jersey is headed.

⇒ What issues will the new president of the Medical Society of New Jersey face?

Writer Bill Berlin interviews R. Gregory Sachs, MD, the 1998-1999 president of MSNJ, and presents his agenda for the coming year.

⇒ What are the possibilities of 3-D computer graphics in medicine?

Three-D computer graphic technology is beginning to serve the needs of physicians and surgeons. Eric Lerner uncovers what 3-D computer graphics offers science and medicine.

⇒ How is the role of radiation oncology changing?

Between 50 and 60 percent of all patients with cancer will require radiation treatments at some stage of the evolution of their disease. This article highlights the recent advances in radiation oncology treatment.

⇒ Tune in for Newswatch, Mail Stop, F.Y.I., Editor's Notes, Online@MSNJ, and Calendar.

Medical Society of New Jersey

Long Term Care Insurance Program

Ensuring a Secure Future by Preserving Assets

As medical professionals, you know first hand the devastating effects that extended long term care can have on a person's hard earned assets. The cost of nursing home stays can range from \$3,000-\$5,000 per month. The Medical Society of New Jersey endorses The Travelers and CNA Insurance Companies' policies to help you guard against unforeseen tragedies. Through a special arrangement with The Travelers and CNA Insurance Companies, members, spouses, parents and in-laws are eligible for a premium reduction.

IMPORTANT FEATURES OF THE MSNJ ENDORSED LONG TERM CARE INSURANCE PROGRAM

- ◆ Available Ages 45-84
- ◆ Specialty Plans Available Ages 80-100
- ◆ Benefits up to \$250/day
- ◆ No prior hospitalization required
- ◆ Several waiting periods
- ◆ Alzheimer's, senility covered
- ◆ Lifetime benefits available
- ◆ Guaranteed renewable for life
- ◆ Coverage for custodial, skilled and intermediate care as well as adult day care
- ◆ Available to your spouse, parents and in-laws
- ◆ Waiver of premium benefit
- ◆ Inflation protection available

DISCOUNT FOR MEMBERS OF MSNJ, SPOUSES, PARENTS AND IN-LAWS

For more information, please call

DONALD F. SMITH & ASSOCIATES

A division of THE COPELAND COMPANIES'

Two Tower Center, P.O. Box 1063
East Brunswick, New Jersey 08816-1063

(888) 297-7225

Copeland Associates, Inc.

Medical Society of New Jersey
MSNJ

E V E N T

D A T E

L O C A T I O N

M a y

Dermatology Society Annual Meeting	May 12, 1998	The Manor, West Orange, AMNJ, 609.275.1911
Head and Neck Oncology	May 14, 1998	The Manor, West Orange, AMNJ, 609.275.1911
New Jersey Healthcare Congress	May 14-15, 1998	Convention Center, Atlantic City, 609.275.4000
American Red Cross HIV/AIDS Training	May 16, 1998	Raritan Valley Comm. College, Somerville, 908.526.1200
Women's Peer Education	May 16, 1998	Amity Heights, Bridgeton, 609.455.5125
General Internal Medicine	May 19, 1998	UMDNJ, New Brunswick, 732.235.7430
Pathology of Hemodialysis Access Dysfunction	May 19, 1998	Overlook Hospital, Summit, AMNJ, 609.275.1911
Society of Anesthesiologists Meeting	May 19, 1998	Forsgate Country Club, Jamesburg, AMNJ, 609.275.1911
Radiology Society Meeting	May 21, 1998	UMDNJ-RWJ Medical School, 732.235.7721
Opportunistic Infections in the Respiratory System	May 22, 1998	Newcomb Medical Center, Vineland, AMNJ, 609.275.1911
Radiology Visiting Professor Lecture	May 28, 1998	Saint Barnabas Medical Center, Livingston, 973.533.5803

J u n e

Gastroenterological/Gastrointestinal Endoscopy	June 3, 1998	The Manor, West Orange, AMNJ, 609.275.1911
Ob/Gyn Society Annual Meeting	June 5-7, 1998	Trump Plaza Hotel, Atlantic City, AMNJ, 609.275.1911
Oncology Society Annual Meeting	June 10, 1998	Hyatt Regency, New Brunswick, AMNJ, 609.275.1911
A Day of Learning	June 19, 1998	NJ Institute of Technology, Newark, 973.485.5220
Statewide Conference on Adolescent HIV/AIDS	June 24, 1998	Sheraton, Woodbridge, 973.972.6482
12th World AIDS Conference	June 28, 1998	Geneva, Switzerland

J u l y

Medicine in the Face of the New Millennium	July 2-5, 1998	Westin Rio Mar Resort, 800.888.6235
--	----------------	-------------------------------------

O c t o b e r

Sports Medicine '98	October 7, 1998	MSNJ, Lawrenceville, 609.896.1766
Cancer Survivorship	October 8-10, 1998	Caesars Hotel, Atlantic City, 212.366.6565

John Paul Dizzia, P.C. ATTORNEYS AT LAW

Legal Counseling and Representation to Medical Professionals in administrative, regulatory and disciplinary matters before the State Board of Medical Examiners, the Department of Insurance, the Division of Medical Assistance and Health Services, and in the law relating to professional rights, responsibilities, ethics and practice issues.

Member:

- National Health Lawyers Association
- Health and Hospital Law Section,
New Jersey Bar Association
- New Jersey Association of
Professional Mediators

108 North Union Ave.
P.O. Box 886
Cranford, N.J. 07016

Call: (908) 276-6111
FAX: (908) 276-5838
E-Mail: JPD LAW@WORLDNET.ATT.NET

A NEW PACE IS SET FOR MEDICAL OFFICES



Your medical practice is a business, and if that business does not run efficiently, it will affect your patient and public relations. I'm Mary Ann Hamburger, and I've set a new pace for your administrative office personnel, that's steady

and streamline. Simply call one number for a complete turn-key approach, assuring peak performance in your office. I'll hire and train your staff and help with patient flow. I'll reorganize your billing systems and update all of your CPT and ICD codes. I can even help you *sell your practice*. You know what you need, but handling it is tedious. Rely on an *expert*. Let me evaluate, recommend and reorganize your total office.

OFFICE REORGANIZATIONS
START TO FINISH
MARY ANN HAMBURGER
A S S O C I A T E S

THE SPECIALIST'S SPECIALIST
74 HUDSON AVE. MAPLEWOOD, N.J. 07040
973-763-7394

Our unique approach to malpractice insurance can improve your cash flow.

Most New Jersey malpractice insurance policies require you to purchase a reporting endorsement — known as a tail — to protect against claims that may occur during retirement. B.C. Szerlip offers a unique policy from an A+ rated company that does not include an annual tail premium. In fact, if you maintain coverage with us until retirement, you'll *never* have to purchase a tail, and you'll still be protected.

That's just one example of the creative ways that B.C. Szerlip has discovered to help doctors with their long-range financial planning.

At B.C. Szerlip, we take a big-picture view of your practice, offering you comprehensive insurance and financial planning services. You can benefit from our nearly two decades of experience providing malpractice insurance for medical offices both large and small. In addition, our financial planners can offer strategic guidance for the overall health of your business affairs, so you can stay focused on the health of your patients.

We'd like to give you a taste of our full-service approach by sending you *The Managed Care Survival Kit for Physicians*. To receive your complimentary copy of this useful guide, please call us at 800-684-0876.

BCSZERLIP INSURANCE AGENCY INC.

99 WOOD AVENUE SOUTH, PO BOX 217
ISELIN, NJ 08830-0217
800-684-0876 • 732-205-9800
FAX: 732-205-9496
E-MAIL: bcszerlip@aol.com

*Professional Insurance Services
for Health Care Providers*

HealthCare Institute of New Jersey

This May issue of *New Jersey Medicine* is noteworthy for two reasons; it introduces a new look for the magazine and is the first issue specially devoted to one of New Jersey's major health care industries. The research-based pharmaceutical and medical device industry in our state employs more than 60,000 persons.

The HealthCare Institute of New Jersey was formed in 1996 and began its operations on January 1, 1997. With offices in New Brunswick, the organization, which began with 11 charter members, now represents 16 major pharmaceutical and medical device companies.

Robert N. Wilson, vice-chairman of the Board of Johnson & Johnson, is the first chairman of the HealthCare Institute of New Jersey.

At the public launch of the organization during Pharmaceutical Research Day in the state capital of Trenton last year, Wilson said to Governor Christine Todd Whitman, "We in the pharmaceutical and device industry here in New Jersey have always been proud to be part of the Garden State. I think you know most of our companies, and each has a fine reputation on its own. It has been a concern to us, however, that the industry as a whole is not as known or as well understood as the individual companies."

"New Jersey is very important to the pharmaceutical and medical

device industry and it is our belief that the industry should be important to New Jersey. In order to help foster that understanding, these companies have joined together to form the HealthCare Institute of New Jersey."

Later on that same day, Patrick J. Zenner, president and chief executive officer of Hoffmann-La Roche spoke to a luncheon audience of legislators and nonprofit leaders from around the state about the significance of research to the industry and patients around the world.

Zenner, who will soon succeed Wilson as chairman of the HealthCare Institute of New Jersey, introduced research leaders from all the member companies, who every day are at work searching for cures and treatments on more than 60 different diseases.

In doing so, he commented, "This industry has an exciting story

to tell. Today, and every day in the work of the HealthCare Institute we are emphasizing the word research. The mission of research is best exemplified by the women and men who are with us today. They are the people in the labs devoting countless hours to finding new cures."

Wilson and Zenner are just two of the leaders of an industry that considers the Garden State to be the "medicine chest of the nation" if not, indeed, the world. With its recent membership additions, the HealthCare Institute of New Jersey companies have locations in 16 of the 21 counties; a total of 120 sites in 72 different municipalities in New Jersey.

During the 1990s, one-third of all the significant new drugs approved by the federal Food and Drug Administration have come from New Jersey companies.

The members of the HealthCare Institute of New Jersey

American Home Products Corp.
Becton Dickinson and Company
Bracco Diagnostics, Inc.
Bristol-Myers Squibb Co.
C.R. Bard, Inc.
Hoechst Marion Roussel
Hoffmann-La Roche Inc.
Pfizer Inc. (Howmedica, Inc.)
Johnson & Johnson
Knoll Pharmaceutical Co.
Merck & Co., Inc.
Novartis Pharmaceutical Corp.
Novo Nordisk Pharmaceuticals, Inc.
Nycomed Amersham Imaging Americas
Schering-Plough Pharmaceuticals
Warner-Lambert Co.

Joseph Mahady, Trustee
John W. Galiardo, Trustee
John J. Cornille, Trustee
Richard J. Lane, Trustee
William H. Longfield, Trustee
Richard J. Markham, Trustee
Patrick J. Zenner, Vice-Chairman
Frederick Telling, Trustee
Robert N. Wilson, Chairman
Carter H. Eckert, Trustee
Raymond V. Gilmartin, Trustee
Wayne P. Yetter, Trustee
William S. Poole, Trustee
Daniel L. Peters, Trustee
Raul Cesan, Trustee
Anthony H. Wild, Trustee

LET'S TALK!

NEED A BUSINESS LOAN?
CALL US FOR...

EXPERT HELP
FABULOUS SERVICE
COMPETITIVE RATES
FAST APPROVALS AND CLOSINGS

Loans up to approx. \$1,500,000 under the U.S. Small Business Administration Guaranteed Loan Program.
Approvals in 24 hours, or less.
Preferred (PLP) lender in New Jersey, New York and Pennsylvania.



Call 1-800-SBA-2005
ask for the "SBA Specialist"
PRESTIGE STATE BANK

 Equal Housing Lender Equal Opportunity Lender

Member FDIC

MAC



The Medical Manager[®]

Practice Management Software

A fully integrated practice management solution

Over 16 years' experience in providing
healthcare automation solutions

Provides an open system architecture
and flexibility for specialized needs

Designed for small group practices to large
Integrated Delivery Systems

Overwhelming national presence

Learn more about how Medical Manager Corporation and
The Medical Manager system can meet your needs. Contact us
at 800.677.7784, 201.808.0088, or www.medicalmanager.com.

**Medical
Manager**
Corporation

RTI, Inc. and Medix

Empowering the Industry Through Partnership

Saturday, June 27, 1998

18th ANNUAL Advances in Gastroenterology Course

Trump Plaza/World's Fair
Atlantic City, New Jersey

Course Director:

Anthony J. DiMarino, Jr., MD

For more information, please call
(609) 848-1000

Registration Department



Thomas
Jefferson
University

Jefferson
Medical
College

Jefferson Medical College of Thomas Jefferson University, as a member of
the Consortium for Academic Continuing Medical Education, is accredited
by the Accreditation Council for Continuing Medical Education to sponsor
continuing education for physicians. As usual, CME credits will be offered.

INTERNATIONAL COLLEGE OF ACUPUNCTURE & ELECTRO-THERAPEUTICS

*(Permanently Chartered by the University of the State of New York,
State Education Department)*

1998 Seminars & Workshops & 14th Int. Symposium

ACUPUNCTURE & ELECTRO-THERAPEUTICS in Clinical Practice

25 credit hours can be earned by attending
one three-day weekend (Friday-Sunday) session 9 am-7 pm

May 15-17, 1998 Holiday Inn, Manhattan
June 19-21, 1998 440 W. 57th St, NYC between 9 & 10 Ave.
Sept. 18-20, 1998 Hotel 212-581-8100 during meetings

14th Annual International Symposium, Oct. 22-25, 1998
the School of Int'l Affairs, Columbia University

In addition to holding 7-8 seminars & workshops per year, the International College of Acupuncture & Electro-Therapeutics organizes an Annual International Symposium every October at the School of International Affairs, Columbia University, NYC and publishes *Acupuncture & Electro-Therapeutics Research*, *The International Journal* quarterly, through Cognizant Communications and is listed by 15 major international indexing periodicals (*Index Medicus*, *Current Content*, *Excerpta Medica*, etc.), is recognized as a major leading journal in the field. The most prestigious and internationally recognized, "Fellow of the International College" (F.I.C.A.E.) will be awarded to members of the College who present a minimum of 2 original research papers during the annual International Symposium and publish them in the official journal, or who have made significant contributions in the field.

These seminars & workshops train physicians and dentists in the latest theories and techniques of manual & electro-acupuncture, TENS & simple non-invasive diagnostic methods (including cardiovascular, neuro-muscular, central nervous systems & Bi-Digital O-Ring Test).

For information, contact Dr. Y. Omura, MD, ScD, FICAE, 800 Riverside Drive (8-1), NY, NY 10032; 212-781-6262, Fax 212-923-2279 or Dr. Richard Simon, PhD, 212-662-7022 or Ms. Sandra Beckman, MA, 212-679-8986. All ICAE meetings are accredited by the New York State Boards for Medicine and Dentistry toward the 300 accredited hour requirement for the Acupuncture Certificate in New York State. Also eligible for AMA/CME Category I credit. MSSNY designates this CME activity for AMA/CME Category 1 credits toward Physician Recognition Award.

NEW JERSEY MEDICINE CLASSIFIED INSERTION ORDER

AD RATES

Classified Section

\$ 1.00 per word

\$45.00 minimum

Confidential Box # = 5 words

Display ad in Classified Section

\$60.00 first 1" per column

\$30.00 each additional 1/2" per column

CLASSIFIED AD PLACEMENT

MAIL—NEW JERSEY MEDICINE

370 Morris Avenue

Trenton, NJ 08611

FAX—609-393-3759

DEADLINE—10th of month preceding month of issue

QUESTIONS—Call 609-393-7196

WORDING OF AD CANNOT BE TAKEN VERBALLY BY PHONE.
PLEASE WRITE OR TYPE CAREFULLY. AD WILL BE PLACED
EXACTLY AS RECEIVED.

BOLD HEADING (optional)
(limit, 20 characters per line)

Requested Category:

Body copy
(35 characters per line)

Classified Section

Number of Words

Minimum \$45 \$ _____

Member Physician

Discount— $33\frac{1}{3}\%$ (\$)

Per Issue \$ _____

× Number of Issues

AMOUNT DUE \$ _____

Display Ad in Classified Section

1st Inch = \$60.00

\$ _____

Add'l 1/2" x \$30.00

\$ _____

Total

\$ _____

Member Physician

Discount— $33\frac{1}{3}\%$ (\$ _____)

PER ISSUE

\$ _____

× NUMBER OF ISSUES

AMOUNT DUE

\$ _____

ALL CLASSIFIED ADS MUST BE PRE-PAID

Please make check payable to the
Medical Society of New Jersey

When professional health law counsel is called for,
call the firm the experts are calling.



For years health care providers and businesses have been calling Theodosia A. Tamborlane P.C. when they needed accurate information, insightful commentary and practical advice. That's because Theodosia A. Tamborlane P.C. successfully navigates through the maze of government activity at both state and federal levels every day.

Today physicians, hospitals, nursing homes, assisted living, ambulatory care

facilities, home health care agencies and other providers turn to this firm for legal services including managed care contracting and corporate compliance plans. It's little wonder why leading health law publications and the nation's most prestigious legal, medical and business associations keep calling Theodosia A. Tamborlane P.C. to keep their members up to date. When you need professional legal counsel select the firm that knows the issues ...

Theodosia A. Tamborlane, P.C.



THEODOSIA A. TAMBORLANE, P.C.

COUNSELORS AT LAW

1044 ROUTE 22 WEST, MOUNTAINSIDE, NEW JERSEY 07092

908-789-7977

Member, American Medical Association Doctors Advisory Network

Charter Member, American Association of Physician-Hospital Organizations-Integrated Healthcare Delivery Systems

CLASSIFIED ADS

110 OPENINGS PHYSICIANS

BC/BE ANESTHESIOLOGIST

Pain Management Only—New Jersey (Central/Northern—½ hr. from N.Y.C.). Outstanding private practice opportunity for BC/BE Anesthesiologist. Pain Fellowship is a plus. F/T or P/T. Most established pain group in the state. No night calls or wknds. Avail. 07/01/98. Fax short C.V. & cover letter to 732-651-0375.

BC/BE ANESTHESIOLOGIST

Immediate position available for a BC/BE Anesthesiologist to join a private group of 12 MD/CRNA's in a growing practice. All types of anesthesia except OH. Located in a rapidly developing area, 15 miles from Philadelphia, 1 hour from NJ Shores. Competitive Salary, Benefits Package and Partnership Track. Send C.V. and inquiries to Robert A. Hirsh, MD, Chairman Dept. of Anesthesia, Burlington Anesthesia Assoc., 1632 Route 38, Suite 9, Mt. Holly, NJ 08060.

BC/BE PEDIATRICIAN

To join Pediatric Group Practice. Competitive salary. Early Partnership. Please send CV to Cape Pediatric Associates, P.A., 301 Dennisville Rd., Cape May Court House, NJ 08210.

FAMILY PRACTICE MORRIS COUNTY

Excellent opportunity for a physician to join an established Family Practice in Morris Plains, Morris County, New Jersey. Salary commensurate with experience. Will introduce. Terms available. Please fax resume ATTN: FAP 516-665-0555.

IM/FP UNION COUNTY

Union County IM/FP Internist seeking Associate within an established group. Unusual Opportunity. Send CV to Confidential Box #139, c/o New Jersey MEDICINE, 370 Morris Avenue, Trenton, NJ 08611 or FAX c/o AMD @ 908-273-1133, "Confidential."

PRIMARY CARE— MONMOUTH COUNTY

Family Practice physician needed F/T to join our expanding group practice. Ideal candidate will possess board certification in primary care, along with some emergency care experience. Primary responsibility will be providing office care. Monmouth County location. Please respond with C.V. to Robert A. Rosen, MD, P.O. Box 8340, Red Bank, NJ 07701, or by fax to 732-219-0108.

130 OPPORTUNITY WANTED

GENERAL PRACTITIONER

General Practitioner, 51 years old, MO & NJ Licensed, only one PG-1 year, foreign graduate, not board certified nor eligible. 23 years experience in General Practice and small ER's; needs temporary work until October 1st or beyond. 314-428-4032.

RADIOLOGIST

Radiologist searching for a part time job. Lot of experience in General Radiology, Ultrasound & Mammography. Flexible hours. Nutley Postal Center #105, 460 Franklin Avenue, Nutley, NJ 07110.

200 PRACTICE FOR SALE

ENT PRACTICE

Gen ENT practice, solo in own building—established 28 yrs—South Jersey Shore area—15 min to Atl. City, 1 hr to Philadelphia. Enjoy the Shore, fishing, etc. Confidential Box #138, c/o New Jersey MEDICINE, 370 Morris Avenue, Trenton, NJ 08611.

CLIFFWOOD

Close to three hospitals. One reception room. Three examining rooms. One consultation room. One billing room. One file room. One convenience room. One large bathroom. Utility room. Ramp access to wheel chair. Private entrance in rear. Parking lot. Completely fenced. One acre property. 732-566-0880 office Hrs. 9:00 am-5:00 pm.

FAMILY PRACTICE

Twenty year old, well established, exclusively Spanish population, primary care in a busy city area, for sale. Great opportunity for dedicated MD committed to quality care. Major HMO affiliated. Please call 973-484-5887 between hours of 11 am to 3 pm.

WEST ESSEX AREA OB-GYN

Practice or Space in Professional Building. Ready for interested party to continue as OB-GYN or other type medical service. Suitable for solo or group. Phone 973-533-9200 Ext. 107. Fax 973-535-8035.

ORTHOPAEDIC PRACTICE

Active Orthopaedic practice for sale. NE NJ (Suburban NYC area) in 1998. Differed financial incentives available for new Orthopaedist. Write: POB 4724, Clifton, NJ 07015.

300 OFFICE RENTALS AND LEASES

EDISON

Office Space—Edison Medi-Plex Building opposite J.F.K. Hosp. Fully equipped, turn-key. Rent day, full day, night. 732-494-6300.

HILLSBORO

Hillsboro Medical Office—1,500 sq. ft. \$1,000/mo. Busy location. Active practices in building. Ideal for new or 2nd practice. Call Dr. Wolinsky 212-476-7789 days or 215-860-8491 eves.

MILLBURN

Medical Arts Building. Millburn Avenue. Fully equipped, turn key. Rent day, 1/2 day, night. Call 973-376-8670.

MOORESTOWN, NJ

Medical Center. Excellent primary network—Family Practice/Pediatrics/OB. Need medical and surgical specialties. S offices available. Excellent Loc 609-235-2651.

310 OFFICES TO SHARE

FORT LEE (BERGEN COUNTY)

Established 15 yr. Chiropractic Practice interested in sharing a 1600 Sq. Ft. space modern office with 5 treatment rooms. Located in a residential area of Fort Lee—5 minutes G.W.B. Turnkey Operation. 201-886-8755

325 MEDICAL BUILDING FOR SALE OR LEASE

LAWRENCEVILLE

2300 sq. ft. Condominium Professional Building. Close to Rt. 1 corridor. Four exam rooms, consultation rooms. Large work areas. Wheel chair accessible bathroom. Two lab rooms. Lounge, storage space built-in. File room. Private entrance in rear. Purchase or Lease anytime between 9:00 a.m. and 3:00 p.m. 609-896-0242.

340 REAL ESTATE HOME/OFFICE

MOUNTAINSIDE

FOR SALE. Home-Office Professional Building. Home—4 bedrooms, 3 full Baths, central air, fireplace, family room, central air, security systems, large basement. Office—5 rooms (large), 2½ baths, central air, separate entrance. 241 New Providence Road, Mountainside 07092. 908-233-2993 (24 hours).

415 MEDICAL BILLING

North American Financial Systems, Inc. A cost medical billing company. Call Mike for information. 975-535-0654.

420 FINANCIAL SERVICE

ALTERNATIVE FINANCING/MEDIATION

Where do you go when banks say "NO"? Our company has access to an extensive network of Alternative lenders willing to go where traditional banks won't. Business Debts that overdue can cause real problems. We reach debts by skillful negotiation. 732-416-0100.

510 EQUIPMENT WANTED

USED DEXA MACHINE

Wanted: A used DEXA (Bone Density Machine) preferably a Hologic. Cash or installment. Please call 24 hours, Page 421-9795 or 609-586-1100 or Eves 609-924-4704 for doctor.

You take care of your patients. We'll take care of the health of your practice. Our group of health care accounting specialists provides the medical community with the right type of analysis and counseling to be successful.

Since we're dedicated to increasing your profitability, never simply reporting it, we'll see

to it that your practice stays healthy for many years to come. To experience our unique approach, please call Ira S. Rosenbloom, Managing Director, at 973-882-1100.

PRACTICE GOOD FINANCIAL MEDICINE.

Mintz Rosenfeld & Company LLC
Profitability Consultants • Certified Public Accountants
60 Route 46 East, Fairfield, NJ 07004
Tel: 973-882-1100 Fax: 973-882-1560

OUR FOCUS IS YOUR SUCCESS.

Lowest Premiums for Quality Malpractice Insurance

The Joseph A. Britton Agency can help make it happen. If you are a preferred risk¹, you can qualify for preferred rates². Compare these annual premiums at occurrence limits of \$1,000,000/\$3,000,000:

• Anesthesiologists	\$ 8,572
• General Surgeons	\$18,453
• Internists	\$ 5,331
• Ob-Gyns	\$39,000
• Radiologists	\$ 5,331
• Plastic Surgeons	\$23,350
• Psychiatrists w/ect	\$ 2,937
• Urologists	\$11,993

With more than 25 years of experience, the Britton Agency has proven exceptional in packaging malpractice insurance. Our professional staff and size assure you the benefits of specialized, personal service while offering you insurance at the lowest cost.

Call for a free consultation. Start saving tomorrow.



Joseph A. Britton Agency, Inc.
Healthcare & Professional Liability Insurance
855 Mountain Avenue, Mountainside, NJ 07092
(908)654-6464 • Fax: (908)654-1422 • 1(800)462-3401

¹Underwriting approval required.

²May need groups of 3 or more depending on speciality.

FSHUTZ, POLLAND & ASSOCIATES, P.C.

THE LAW FIRM THAT SPECIALIZES IN HEALTH CARE REPRESENTATION OF PHYSICIANS AND OTHER HEALTH CARE PROFESSIONALS.

OUR AREAS OF EXPERTISE INCLUDE:

Managed Care Contracts with MSOs and HMOs.
Health Care Mergers/Joint Ventures/Acquisitions.
Development and implementation of Compliance Audits and Plans.
Respresentations in Board of Medical Examiner Cases.
Asset Protection/Estate Planning as protection against malpractice suits.
Federal and State Anti-Kickbacks/Stark/Safe Harbor representation.
Medicare/Medicaid/Third Part Audits

OUR EXPERT STAFF CONSISTS OF SPECIALIZED ATTORNEYS AS WELL AS PHYSICIAN-ATTORNEYS.

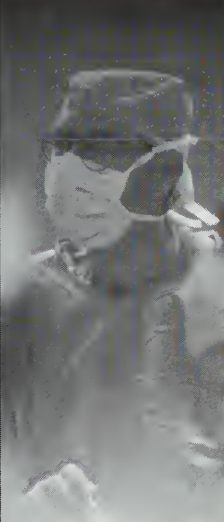
FSHUTZ, POLLAND & ASSOCIATES, P.C.
ATTORNEYS AT LAW

26 LAFAYETTE AVE., HAWTHORNE, NJ 07506
(201) 427-2040

675 THIRD AVENUE, NEW YORK, NY 10017
(212) 949-8484

Web: Lifshutz-Polland.com

BUSINESS OPPORTUNITY



Ambulatory SurgiCenter

Located on First Floor of Medical Professional Building in Passaic County NJ. Fully equipped, elegantly redecorated 3,000 - 5,000 Sq. Ft.

Ambulatory SurgiCenter offers:

- * Office/exam rooms
- * Fully functional OR and recovery rooms
- * Spacious reception area
- * Ample free parking
- * Access to Routes 3, 46 & Garden State Parkway.

This facility complies with all state and HCFA certification requirements, and all state and local fire and safety codes.

**For more information
call 1-800-224-6449
extension 2692**

Photo Finish

With a \$500,000 unrestricted grant from the Bristol-Myers Squibb Foundation, Joseph Takahashi, PhD, is doing groundbreaking research on the workings of internal clocks in the human body.

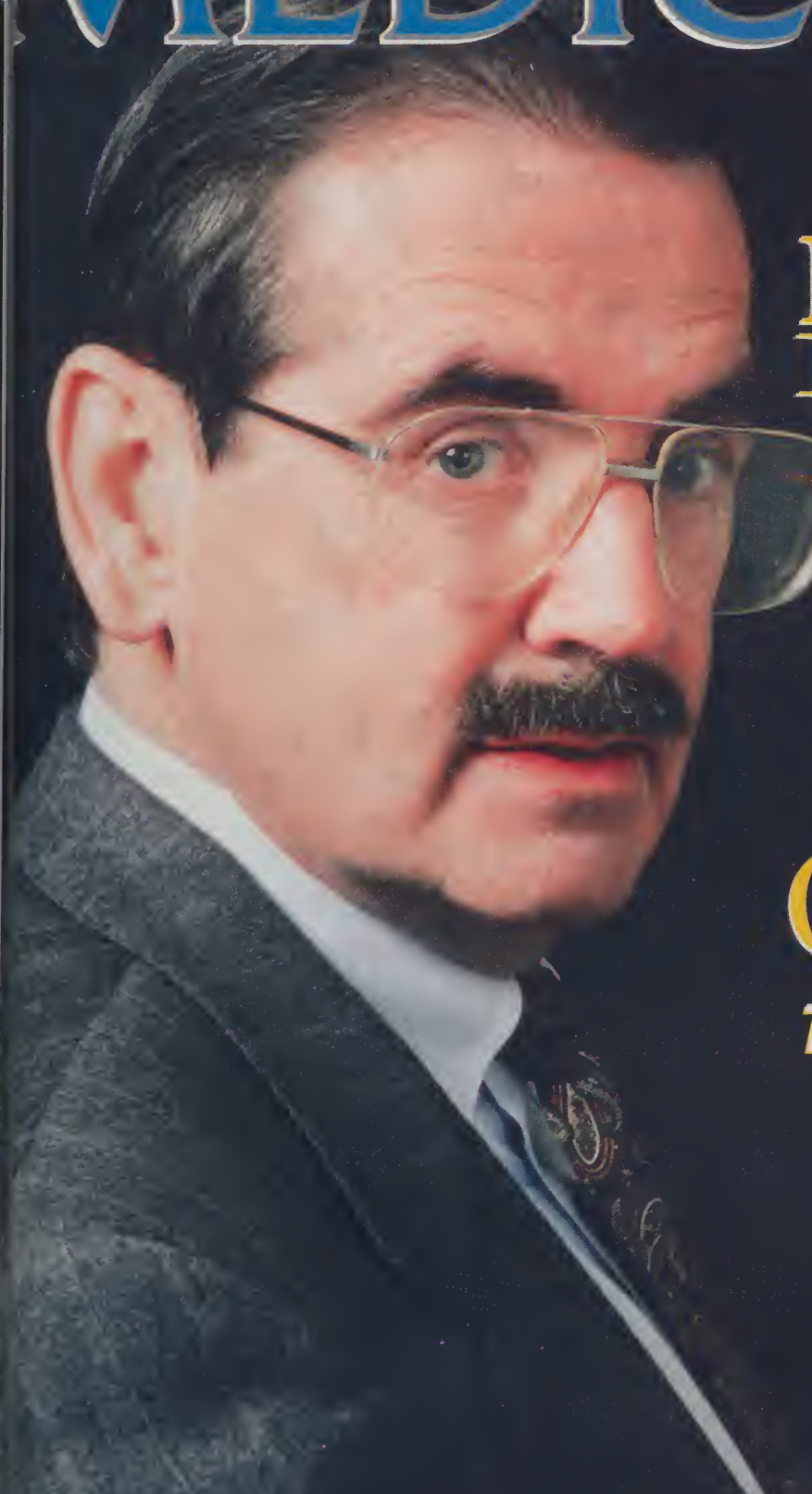


We welcome contributions to Photo Finish (color or black-and-white). Please include a 50-word description of the photograph. Send to Editor, New Jersey Medicine, Two Princess Road, Lawrenceville NJ 08648. Photographs will be returned.

NEW JERSEY MEDICINE

HEALTH CARE IN THE GARDEN STATE

JUNE 1998

A close-up portrait of a middle-aged man with dark hair, a mustache, and glasses. He is wearing a dark suit jacket over a light blue shirt and a patterned tie. He is looking slightly to the right of the camera with a serious expression.

Medicine Man

*He's turning
heads in
health care*

Fatal Obsession

*The power play
with food*

Y - O - U - R

PRACTICE

MADE MORE

PERFECT

WITH OVERHEAD EXPENSE INSURANCE FROM BLANKSTEEN

If you get sick, we'd like to help keep your practice well with overhead expense coverage that can reimburse office salaries, rent, insurance premiums, and utilities during an extended disability. Your needs are special, so call and talk with us. The only time to draw a blank in your insurance is when you fill it in with Blanksteen.



The _____ steen Companies

The Blanksteen Companies 253 Washington Street Jersey City, NJ 07302 201-333-4340 1-800-BLANK-AG
The Blanksteen Companies 161 William Street New York, NY 10038 212-732-9435 1-800-BLANK-AG
The MEDICAL SOCIETY OF NEW JERSEY endorsed plans, including Professional Overhead Expense underwritten by National Casualty Company.

JUL 13 1998

AUSTIN, TEXAS

Newswatch

Who is taking care of medicine?

Activities consuming regulators in the Department of Health & Senior Services these days include reforming the certificate-of-need process, finalizing regulations implementing the Health Care Quality Act, and reviewing hospital licensure standards. When all is done, a more streamlined and patient-centered system should result.

New Jersey physicians apparently won't suffer the fate of Medicare providers in other states. Xact Medicare Services, our state carrier, has notified federal officials that there is no need here to reduce check runs and delay payment of claims.

MSNJ, which led the drive last year to reform the leadership of the American Medical Association (AMA), is going to this month's AMA's annual meeting equipped with several resolutions adopted last month by the MSNJ House of Delegates.

Our resolutions would prevent AMA Board members from being

elected executive vice-president, change Medicare claim denials to read "not covered" rather than "not medically necessary," permit physicians without approved laboratories to perform simple laboratory tests in their offices, establish Medicare provider toll-free hotlines, and toughen HIV reporting.

Other MSNJ resolutions would permit physicians to waive deductibles and copayments for Medicare and Medicaid patients, restrict youth access to tobacco, avoid some year 2000 computer problems, and set medical guidelines for cruise ships.

Evaluation and management coding remains a contentious issue within the medical profession, although AMA officials achieved substantial victories this spring. News reports quoted MSNJ representative George T. Hare, MD, as telling an AMA conclave that "somewhere, among all the papers here, all the papers on my desk, everything that I sign, is a patient. . . . I'd like to get back to what I think I do best—taking care of a patient."

Here's a concept worth remembering: Health and productivity management (HPM) has emerged as a new criterion used by employers to assess their health plans.

This new yardstick provides benefit managers with measures of how quickly employees return to full duties after taking medical leave. Termed "the next generation of analysis" by Perspectives on the Marketplace, HPM may displace average length of hospital stay and other cost-related criteria in evaluating HMOs and other carriers.

If HPM is a new concept, then let's also reintroduce a familiar one, physician-patient communication. Loss Minimizer now endorses longer training programs for physicians, rather than half-day seminars that have not been found to produce substantial changes in physicians' communication.

Meanwhile, The Healthcare Strategist reviewed the Emory University System's recent marketing success, which turned on patient satisfaction surveys that also emphasized communication. Emerging as the "top factors of overall patient satisfaction" at Emory were, in order, physician's manner, staff interaction, telephone and scheduling times, and access. The first of these factors obtained a score two and one-half times higher than the second factor.

Regulators in New York State, led by Attorney General Dennis C.

Vacco, have determined that most HMOs in the Empire State failed to provide enrollees with required information about benefits. Those HMOs that don't correct their deficiencies, said Mr. Vacco, "will see me in court."

State Health Notes, which reported the New York development, also noted the recent decision by Federal District Court Judge Stanley Brotman in New Jersey. The court compelled an HMO to answer a malpractice claim in state court.

The decision involved the "ERISA pre-emption" that allows federally regulated employee benefit plans to avoid state requirements affecting benefits. Reflecting a growing trend in litigation, the judge indicated that state requirements affecting quality of care, though, can apply to ERISA plans.

Most patients treated for schizophrenia are not receiving proper doses of antipsychotic medications or appropriate psychosocial interventions, according to the Schizophrenia Patient Outcomes Research Team funded by the Agency for Health Care Policy and Research (AHCPR). More attention to mental health care may result from the National Com-

mittee for Quality Assurance's inclusion of depression in new draft performance measures for HMOs.

Another AHCPR study determined that 1.7 million more smokers would quit each year if their physician routinely advised patients to quit. (MSNJ has developed a simple card for such use by physicians.) AHCPR's Research Activities summarized a Rutgers University study that found that ex-smokers are hospitalized no more frequently than lifelong non-smokers.

Tobacco control may be weaker if Congress ignores the state attorneys general tobacco settlement and instead enacts its own version. According to *Medicine & Health Perspectives*, advertising restrictions are "the most valuable asset" for efforts to reduce youth smoking and "the most certain casualty of the deal's collapse." (Many public health advocates oppose any deal that would restrict lawsuits against tobacco companies. Is there no limit to people's faith in litigation as a public health and health care strategy?)

Clinic-wide diabetes care guidelines, emphasizing intensive physician involvement with patients, are

touted in another AHCPR study. Diabetes and depression are possible subjects for efforts in New Jersey to produce outcome-oriented standards for the American Medical Accreditation Program.

Many health care providers are worried about carriers' ability to process claims when the Year 2000 glitch hits. But, the Blue Cross/Blue Shield Association counters that hospitals and physicians may be unable to correct their own systems in order to communicate with carriers electronically.

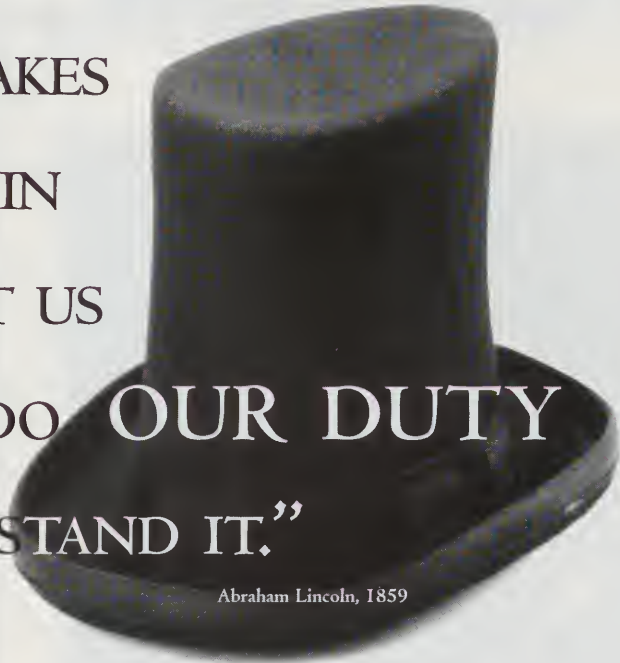
In a broadly distributed *Issue Brief*, the widely respected Center for Studying Health System Change has tossed a bucket of cold water on the Clinton administration's plan to expand Medicare eligibility to the near elderly.

Uninsured individuals who would be eligible under the plan tend to be too poor to buy in, according to data from the Community Tracking Study's Household Survey, yet are in worse health than insured people of the same age.

Beverly Lynch's words occupied this space last month. Thanks to her, and kudos to the staff and designers of our re-formatted *New Jersey Medicine*.

Neil E. Weisfeld

“LET US HAVE FAITH
THAT RIGHT MAKES
MIGHT, AND IN
THAT FAITH LET US
DARE TO DO OUR DUTY
AS WE UNDERSTAND IT.”



Abraham Lincoln, 1859

Setting rates is one of the most challenging tasks an insurer faces. At Princeton, we balance doctors' desire for low-cost professional liability insurance protection with the need to bring in sufficient funds to pay claims. Responsible rate setting, including savings for doctors with good claims experience, is in line with our longstanding commitment (one score and counting) to serve policyholders this century and beyond.

For a policy that delivers value in return for your hard-earned premium dollars (and cents), consult one of the independent agents who represent Princeton or call us at **1-800-433-0157**.



Princeton Insurance Company

Professional Liability

Office Package Policy

Workers Compensation

Rated A- (Excellent) by A.M. Best Company 746 Alexander Road • Princeton, New Jersey 08540

DOCTOR, DOCTOR.



To get the results you desire,
call the marketing doctors at
Three Bears Communications.
We'll get it "just right" for you, just as
we have for the newly re-designed
New Jersey Medicine magazine.



THREE BEARS COMMUNICATIONS
ADVERTISING • MARKETING

20 NASSAU STREET, PRINCETON, NJ 08542
609-688-1400

NEW JERSEY MEDICINE

JUNE 1998

Editor-in-Chief **Howard D. Slobodien, MD**
Executive Editor **Geraldine R. Hutner, MA**
Assistant Editor **Nancy M. Propsner, BA**
Editorial Assistant **Karen Cuozzo, BS**
Advertising **Cookson Media Services**
Production **Trentypo, Inc.**
Graphic Design **Three Bears Communications**
Cover Photo **Double Exposure**

President and Chair **R. Gregory Sachs, MD**
President-Elect **Irving P. Ratner, MD**
First Vice-President **Walter J. Kahn, MD**
Second Vice-President **Angelo S. Agro, MD**
Secretary **Bessie M. Sullivan, MD**
Treasurer **Eileen M. Moynihan, MD**
Immediate Post-President **Carl Restivo, Jr, MD**

MEDICAL SOCIETY OF NEW JERSEY BOARD OF TRUSTEES

S. Manzoor Abidi, MD
Stevan Adler, MD
Angelo S. Agro, MD
Churchill L. Blakey, MD
Donald J. Cinotti, MD
Rajendra Prasad Gupta, MD
David A. Ingis, MD
Philip J. Jasper, MD
Elliot M. Kraus, MD
Giovanni Lima, MD
Mark T. Olesnick, MD
Robert S. Rigolosi, MD
Michael J. Spedick, MD
John W. Spurlock, MD
J. Jerome Cohen, MD, OMSS
Carlo Porcaro, MD, IMG Section
Andrew Kunish, MD, *Speaker of the House*
Valerie Claps, *MSNJ Alliance*
Jamsheed K. Najmi, MD, *Medical Specialty Societies*

REVIEW BOARD

Sofia Anthony, MD, Paul W. Armstrong, Esq.,
Richard M. Ball, MD, Stanley S. Bergen, Jr, MD,
Harry M. Carnes, MD, Gary S. Carter,
Elizabeth G. Christopherson, Ellen M. Cosgrove, MD,
The Honorable Len Fishman, Joseph E. Gonzalez, Jr,
Paul J. Hirsch, MD, Ismail Kazem, MD,
Louis L. Keeler, MD, Carol J. Kientz, RN,
James R. Knickman, PhD, Paul R. Langevin, Jr,
George R. Laufenberg, Martin S. Levine, DO,
Henry R. Liss, MD, Gregg Lubinsky, RPh,
Ruth B. Mandel, Michael R. McGarvey, MD,
Julane Miller, Charles M. Moss, MD,
Patricia Murphy, PhD, RN, Tom O'Neill,
Fred M. Palace, MD, Mary Todd, DO,
William H. Tremayne, F. Kevin Tylus,
The Honorable Charlotte Vandervalk,
Joan Verplanck, Paul E. Wallner, DO

Our medical specialists make a practice of creating solutions for physicians like you.

Summit Bank's Healthcare Financial Services Group features some of the finest medical specialists in New Jersey. They understand your industry and the issues facing it. As New Jersey's largest locally headquartered bank, our professionals are specifically devoted to the healthcare industry. That means our customized solutions — from loans to leases — come with something extra: time-tested expertise. If you'd like, we'll even help you find a more efficient way to run your practice. To find out more, call Norm Buttaci, Regional Vice President, 609-987-3561.



Summit, Summit Bancorp and Reach Higher are registered service marks of Summit Bancorp • Summit Bank is a service mark of Summit Bancorp.

25

Focus on health care

Eating disorders: Keeping the plate clean

Eating disorders are serious. Physicians and other health care professionals need to aggressively treat these patients.

31

Special feature

The challenge of graduate medical education

GME plays a major role in academic medicine and in the health policy debate. Where is the debate headed?

36

Public health advances

Liposuction: Be careful in there!

It has revolutionized cosmetic surgery more profoundly than any other surgical technique this century, and the results are dramatic.

41

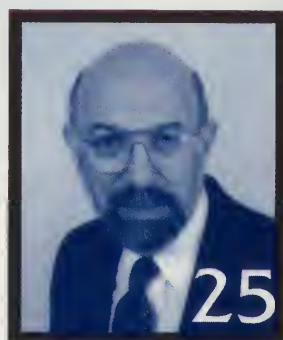
Clinical report

The effects of DHEA

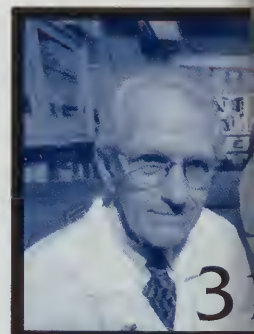
DHEA has been popularized as the fountain of youth. Have we analyzed it enough to know the risks and benefits?



Valerie Claps
leads MSNJA.



Anthony Brickman
on eating disorders.



Stanley Bergen
challenges GME.

YOUR PRACTICE HAS CHANGED SIGNIFICANTLY. SO WHY HASN'T YOUR PRACTICE INSURANCE?

Traditional policies for medical practices are not tailored for you. In fact, the same insurance policy you currently use covers everything from a shoe store to a pizza parlor. Does that sound logical?

The Woodland Group has changed the concept of insuring a medical practice. Today, your medical practice can be protected by The Woodland Alliance Profile, a Risk Management Group created exclusively for physicians offering. . .

- Practice-specific coverage that has and will continue to evolve as the medical industry changes, covering everything from office property and patient charts to diagnostic equipment, general liability and workers' compensation.
- An opportunity to share in profitability of the Risk Management Group through profit sharing returns.

Put Yourself in the Hands of a Specialist.

Call us at **1-800-253-1521** to learn more about The Woodland Alliance Profile or check our website at **www.woodlandgroup.com**.

***The Woodland Alliance Profile...
coverage that is as evolutionary
as your practice.***



- Medical Malpractice
- Managed Care Liability
- Group Disability
- Group Term Life
- Homeowners/
Automobile

1-800-253-1521
<http://www.woodlandgroup.com>



43 In the spotlight

1998-1999 MSNJ President: R. Gregory Sachs, MD

Taking center stage is the new president of the Medical Society of New Jersey as he confronts the challenges of his profession.

47 Financial matters

Providing protection for New Jersey physicians

New Jersey physicians have more power and protection than their colleagues nationwide. The key is to maximize such potential.

51 Current trends

The field of radiation oncology

New techniques and updated methods improve survival outcomes and the quality of life as radiation oncology zooms into the 21st century.

55 Computer.med

3-D computer graphics for medicine

Should physicians rely on 3-dimensional computer graphics to obtain a firm diagnosis or to prepare patients for surgery?



Preparing a patient for treatment in the radiation oncology department with new techniques and updated methods.

DEPARTMENTS

1 Newswatch

MSNJ goes to the AMA to talk about Medicare; another issue is physician communication.

12 Mail Stop

For whom? For what? For you!
So say our letter writers.

16 F.Y.I.

Doctors on the go; recognitions for moving up in the medical ladder.

19 Editor's Notes

How many needle exchange programs does it take?
The answer is clear, according to our editor.

22 Online @ MSNJ

Health care on the Internet. It is booming. But you have to be careful out there.

58 Calendar

Current listing of medical meetings around the state during the summer and the fall.

64 Photo Finish

A look at a previous century in the operating room at South Jersey Hospital-Bridgeton.

Ever wish your broker, your trust officer
and your banker had more in common?



A single vision of your future, for example?

As a physician, you spend a lot of time serving your patients and managing your practice. Where do you find the time to manage the people who manage your financial affairs? At PNC Private Bank, the team of people that manage your financial affairs can be just that: a team. People who work together, with a common goal: to realize your vision of the future. PNC Private Bank brings together under

one roof every service you need, backed by 150 years of professional money management experience and the resources of one of the country's largest financial institutions. No conflicts of interest. No misinterpretations. Just the synergy that can only come when everyone who works with you works with each other as well. Call 1-888-844-1565 to learn more about the difference at PNC Private Bank.

PNC PRIVATE BANKSM

Visit us on the World Wide Web. Our address is <http://www.pncbank.com>

Investments • Trusts • Banking Services

PNC Private Bank is a service mark of PNC Bank Corp. Banking and trust services are provided: by PNC Bank, National Association in Pennsylvania, New Jersey, Kentucky, Ohio and Indiana; by PNC Bank, New England in Massachusetts and Connecticut; by PNC Bank, Delaware in Delaware; and by PNC Bank, FSB in Florida. Members FDIC. Brokerage services are offered through PNC Brokerage Corp, a registered broker-dealer and member SIPC. PNC Brokerage Corp is a subsidiary of PNC Bank, National Association, which is not a broker-dealer.



UNPRECEDENTED ACCOUNTABILITY
CONFLICTING PERFORMANCE CRITERIA
MULTIPLE, FRAGMENTED PROCESSES
TIME-CONSUMING
MORE DOCUMENTATION
LESS PATIENT CARE
HIGH COST
DUPLICATIVE OFFICE SITE REVIEWS
INCONSISTENT CREDENTIALING
NEVER-ENDING PAPERWORK
ADMINISTRATIVE HASSLES

Our solution has arrived.

One Time

One Source

One Standard



American
Medical
Accreditation
Program

With the new American Medical Accreditation Program (AMAP), physicians complete an application **ONE TIME**, have their credentials primary-source verified **ONE TIME**, and have an on-site office review **ONE TIME**.

AMAP then provides an Accreditation report and certificate to each physician who meets the AMAP national standard.

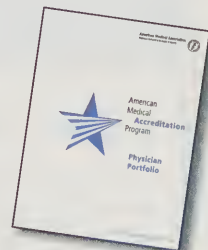
AMAP will provide a complete portfolio of verified credentials, office site visit and other frequently requested information to each health plan and employer that uses AMAP and with whom the physician is affiliated.

The American Medical Accreditation Program is a voluntary, comprehensive accreditation program that measures and evaluates individual physicians against national standards, criteria and peer performance in five areas: **Credentials, Personal Qualifications, Environment of Care, Clinical Performance, and Patient Care Results.**

Meeting and maintaining AMAP's high standard earns a physician AMAP Accreditation – a new national benchmark of physician quality.

AMAP, your one source for the new national standard of physician quality information, has arrived.

To learn more about the many benefits AMAP has to offer *your* organization, call the AMAP Resource Center at 1-888-881-AMAP (2627) or visit the AMAP Web site at <http://www.ama-assn.org>.



The standard in quality physician care.

American Medical Association
Physicians dedicated to the health of America



For whom? For what?

Last year, Ricky Watters, running back for the Philadelphia Eagles, deliberately dropped a pass intended for him over the middle of the field as he was about to be crushed by an opposing defender. His response to public scrutiny was, "For whom? For what?" In essence, they don't pay him enough to take a high risk of injury that may end his career.

Similarly, changes in ob/gyn over the past five years have made each and every practicing physician think about the same situation. All of this mindset has been brought on by managed care. Managed care plans have significantly decreased physician reimbursement, demanded more outpatient and office procedures to lower costs, allowed for shorter hospitalizations for gynecologic and obstetric patients, denied coverage for pre-existing conditions, and increased clerical work for physician office staff pertaining to pre-certification and referrals, while decreasing the quality of care for patients. All this amounted to increasing risk while giving lower fees to the practicing physician.

At some point, something has to give. Will it be less doctors seeing more patients when they already are overburdened with work? Will it be the end of solo private practice as physicians merge practices or join

hospital networks to cut overhead? Will it be the depersonalization of patient care while the assembly line of health care "providers" emerge? Will there be a decrease in medical school enrollment secondary to the discouragement of qualified potential applicants? Will there be decreased incentive to take on high-risk surgical procedures at such low reimbursement and high malpractice risk? Will we see more deaths because of all this?

Many physicians have become complacent while allowing managed care to run their practices as a "business." Is this type of care right for the patient? In this system, often the patient must choose a new physician because her physician of many years was forced out of the managed care plan or doesn't participate for various reasons. The patient then must undergo referral from primary care providers for ludicrous reasons when in fact her ob/gyn may be the only physician that examines her regularly. After

her examination, if she needs lab work or x-ray studies, she may be sent far, since the nearest center may not have a contract with the managed care company involved. If surgery is indicated, she may be sent for second, or third, opinion and often denied surgery by a "medical director" of the managed care plan who most often doesn't even practice ob/gyn or has not studied various alternative treatments. After surgery, even with the slightest complication, or none at all, she may not be ready for discharge but is sent home anyway since the managed care system won't cover her stay even if indicated medically.

What is the solution to this sinking ship of medicine? It's not simply patching up holes since physicians don't want to practice patched up medicine. Recently, in New Jersey, the legislators have been trying to change the injustices of managed care. However, serious changes to return quality care will not occur until our patients become so dissatisfied, discouraged, and/or disgusted with the lack of consideration and care they are receiving—or not receiving—that they will do something about it and demand changes. When that time comes, physicians can answer the question, "For whom? For what?" by saying, "For you!"

Joseph C. Riggs, MD

Requirements for letters

You submit a letter, fax (609.896.1368), e-mail (info@MSNJ.org), or mail your letter to New Jersey Medicine, Two Princess Road, Lawrenceville NJ 08648. Letters should be typed and double-spaced and should be no longer than 400 words with 4 references, if necessary. Include your full name, affiliation, address, and telephone number.

Letters are published at the discretion of the editor-in-chief and are subject to editing and abridgment. Letters may be published on MSNJ's web site, <http://www.msnj.org>. Financial associations or other possible conflicts of interest must be disclosed. Letters represent the opinions of the authors.

Lowest Premiums for Quality Malpractice Insurance

The Joseph A. Britton Agency can help make it happen. If you are a preferred risk¹, you can qualify for preferred rates². We are also the best source for IPA, PHO, and Healthcare network accounts. Compare these annual premiums at occurrence limits of \$1,000,000/\$3,000,000:

Internists	\$ 5,331	• General Surgeons	\$18,453	• Neurosurgeons	\$43,448
Ob-Gyns	\$39,000	• Urologists	\$11,993	• Psychiatrists w/ect	\$ 2,937
Radiologists	\$ 5,331	• Plastic Surgeons	\$23,350	• Anesthesiologists	\$ 8,572

With 30 years experience, the Britton Agency has proven exceptional in packaging malpractice insurance. Our professional staff and size assure you the benefits of specialized, personal service while offering you quality insurance at the lowest cost.

Call today for a free consultation - Start saving tomorrow



Joseph A. Britton Agency, Inc.

Healthcare & Professional Liability Insurance
855 Mountain Avenue, Mountainside, NJ 07092

(908)654-6464 • Fax: (908)654-1422 • 1(800)462-3401

¹Underwriting approval required. ²May need groups of 3 or more depending on specialty.



Druker, Rahl & Fein

Business Consultants
Certified Public Accountants

We have your prescription to profitability

We're Druker, Rahl and Fein, the accountants and advisors
to physicians and health care providers.

...Managed Care..Government Regulations

..the industry is changing..quickly.

How will these changes affect your practice?

You have questions and you need answers.

Our medical services experts will assist you

in developing a strategy to

succeed in this dynamic environment.

Leaders in:

Cost Accounting • Strategic Planning • Group Practice Formation • Tax
Managed Care Analysis • Practice Valuations • Practice Management

200 Canal Pointe Boulevard • Princeton, NJ 08540-5998 • 609-243-9700 • FAX 609-243-9799

Contact Robert J. Rahl, CPA

Average physician fees

Commenting on the Newswatch in the March issue of *New Jersey Medicine*, the numbers for mean and median fees for an office visit are meaningless! With more than 38 percent of care covered by managed care contracts, we can charge what we want but take what we get.

Sheldon S. Schoen, MD

The war against managed care

That public opinion may be beginning to turn the tide on health maintenance organizations, as pointed out in Ellen Goodman's column of April 6, 1998, is music to doctors' ears, and should elate patients as well.

The average patient, when queried about care, will criticize the system and doctors as a group, but praise his or her own practitioner. Perception has it that doctors are money-motivated abusers of the system, taking advantage of patients, the unlucky and ill-fated victims of disease. And, of course, there invariably will crop up a horrific tale of inattention, callous attitudes, and unprofessional care.

I don't doubt that occasional cases such as these exist, but what isn't observed is the concerned, ethical, well-informed, and educated majority of patient advocates out there

in the profession who, together with their sick, are doing the right thing in the best way they know, battling not just the illness but the system. Right—dealing with the HMOs.

I was a medical director when the wave began to wash over New Jersey, when the system began changing from traditional indemnity to managed care. Fairly abruptly, hospitals and doctors began experiencing the squeeze and the ultimatum: threat of loss of patients and income unless the behemoths were fed and satisfied. And the one thing that satisfied managed care was less expensive care. Where did that leave the patient? The for-profit managed care company has its stockholders to pay. Do they really care about the patient? Do they assume any of the risk? Do they care how long it takes to reach someone to get approval for an admission or procedure?

In offices throughout the United States, doctors have to employ people full time to call HMOs virtually every minute of every day, and has-

sle them until a needed treatment or test is approved. This is done not by a doctor, but usually by a paraprofessional who is employed to talk to a managed care doctor/executive. Current professional fees are reduced, yet the cost of practicing is greater; the risks born by doctors who don't do appropriate tests and treatments are greater, and things are becoming more, not less, sophisticated.

What rational, ethical practitioner would dodge and weave, scrimp and scavenge, to avoid something absolutely needed by a patient?

So who is being hurt by these middlemen, these accountants, these HMOs, and other managed care entities? Patients, doctors, and hospitals. And is medical care worse? Probably. More of a hassle? Definitely. Longer waits? For sure. Less efficient? Yup. But less professional or ethical, no way.

It's about time the public and the physicians joined forces to heal this sore. Advocacy groups should lobby loud and clear for what is best for the patient. Doctors are notoriously poor business people, poor politicians, and not very outspoken when it comes to action against tyranny. But this is an opportunity to do something, with patients as allies. ■

Bruce T. Chodosh, MD

Requirements for letters

To submit a letter, fax (609.896.1368), e-mail (info@msnj.org), or mail your letter to New Jersey Medicine, Two Princess Road, Lawrenceville NJ 08648. Letters should be typed and double-spaced and should be no longer than 400 words with 4 references, if necessary. Include your full name, affiliation, address, and telephone number.

Letters are published at the discretion of the editor-in-chief and are subject to editing and abridgment. Letters may be published on MSNJ's web site, <http://www.msnj.org>. Financial associations or other possible conflicts of interest must be disclosed. Letters represent the opinions of the authors.

Critical Treatment for the Future of Your Practice...



Before It's Too Late

Wilentz, Goldman & Spitzer's Health Care Law Practice Group serves health care professionals regarding: group practice formation and operations; management service organizations (MSOs); physician practice management companies (PPMCs); managed care contracting; physician-hospital organizations (PHOs); independent

physician associations (IPAs); restrictive covenants; and regulatory, employment, tax and litigation matters. **Think of us as preventive medicine for your practice.** For information please call our Health Care Law Practice Group Co-Chairs: Michael F. Schaff at (732) 855-6047 or Francis V. Bonello at (732) 389-5636.

**WILENTZ
GOLDMAN
& SPITZER**
ATTORNEYS AT LAW

"Helping The Health Care Professional"

Woodbridge, NJ • Eatontown, NJ • New York, NY

<http://www.newjerseylaw.com>

A HOT CONCERN

In the next 20 years, it's estimated that across the nation 40 million baby boomer women will be entering perimenopause and menopause, says Joan Hammond, RN, clinical provider, St. Peter's Medical Center. In response, the Mind/Body Institute at St. Peter's Medical Center has created a menopause program. The menopause program is designed to teach participants skills they can use to reduce their symptoms, increase their sense of control, lessen anxiety, and improve their overall health.

DOCTORS ON THE GO

On-the-spot information is necessary for doctors in today's medical environment, says Charles M. Moss, MD, chair of the MSNJ Council on Communications. Franklin Electronic Publishers (888.REX.6400 or www.franklin.com) may have the answer. Get instant drug and diagnostic information with the Pocket PDR® Medical Book System™, a handheld electronic device that provides instant access to a library of well-known medical references.

Another time-saving tool is the REX™ PC Companion, a credit card-size PC card that stores data. The Companion provides data synchronization, eliminating the need for double entry of information for business and pleasure.

A NEW ALLIANCE

Valerie Claps, of Morris County, takes over as the president of the MSNJ Alliance. As a partner with MSNJ, the MSNJ Alliance is a volunteer organization dedicated to promoting health-related education and charitable endeavors. The other officers for the 1998-1999 year are: Gwen Jacobs (Warren County), president-elect; Anna Miranda (Union County), first vice-president; Nella Lima (Essex County), second vice-president; Eileen Martin Cohen (Ocean County), secretary; and Teresa Qureshi (Salem County), treasurer. The directors are Rosi Bohn-Rivas (Mercer County), 1997-1999, Mildred Rispoli (Essex County), 1998-1999, and Roberta Wegryn (Union County), 1998-2001.

HEALTH CARE CHAMPS

Assemblyman Joseph V. Doria, Jr. was awarded the Liberty HealthCare System Foundation's Liberty Achievement Award in recognition of his service to the Hudson County community. Doria—active in the legislative arena since 1979—authored the law requiring 48-hours postdelivery care for mothers and their newborns. Also honored in memoriam was MSNJ member Frank Aquila, MD, a founder of the Meadowlands Hospital Medical Center.

RECOGNITION AWARD

The MSNJ Physician's Recognition Award recognizes the achievements of physicians who have voluntarily completed programs of continuing medical education. MSNJ awards those who expand their knowledge and improve skills through education. Only physician members of MSNJ are eligible to apply for the Physician's Recognition Award. Call JaNoel Bess at MSNJ for an application, 609.896.1766.

SACHS STEPS UP

MSNJ is pleased to welcome Gregory Sachs, MD, as its 206th president. Sachs is a cardiologist affiliated with Summit Medical Group. At MSNJ he has served as a consultant to the Council on Legislation, the Committee on Finance and Budget, a delegate to the House of Delegates, and a member of the Board of Trustees. Also a member of the Union County Medical Society and the AMA, Sachs is a graduate of Georgetown University School of Medicine, in Washington, DC. See the "In the Spotlight" section (page 43) for a question-and-answer interview with Sachs.

MSNJ Officers (1998-1999)

R. Gregory Sachs, MD, President and Chair of the Board of Trustees
Irving P. Ratner, MD, President-Elect
Walter J. Kahn, MD, First Vice-President
Angelo S. Agro, MD, Second Vice-President
Bessie M. Sullivan, MD, Secretary
Eileen M. Moynihan, MD, Treasurer
Carl Restivo, Jr, MD, Immediate Past-President



Valerie Claps



R. Gregory Sachs, MD



Frank Aquila, MD



Pocket PDR® Medical Book System™

PEOPLE IN THE NEWS

MSNJ member **Stuart A. Hirsch, MD**, chair of the Department of Orthopaedics at Somerset Medical Center, has been re-elected treasurer of the American Academy of Orthopaedic Surgeons.

MSNJ member **James Breen, MD**, chair of the Department of Obstetrics and Gynecology at Saint Barnabas Medical Center, was presented the Distinguished Surgeon Award from the Society of Gynecologic Surgeons.

John Shaffer was promoted to senior account supervisor at The MWW Group.

Dr. Robert A. Saporito has been appointed dean of the UMDNJ-New Jersey Dental School, Newark.

Holy Name Hospital, in Teaneck announces the appointment of **Robert L. Koniuta, MD**, as the director of Pediatric Anesthesia and associate director of the Pain Management Center.

Gayathri Sastry, MD, has been named medical director of Inpatient Services for Saint Barnabas Behavioral Health Network.

Joseph Gluck, MD, is the current medical director at the State Board of Medical Examiners; is a member of MSNJ.

The acting president of UMDNJ will be MSNJ member **Stuart Cook, MD**, chair of the Department of Neuroscience, effective July 1.

BARRIERS TO CARE

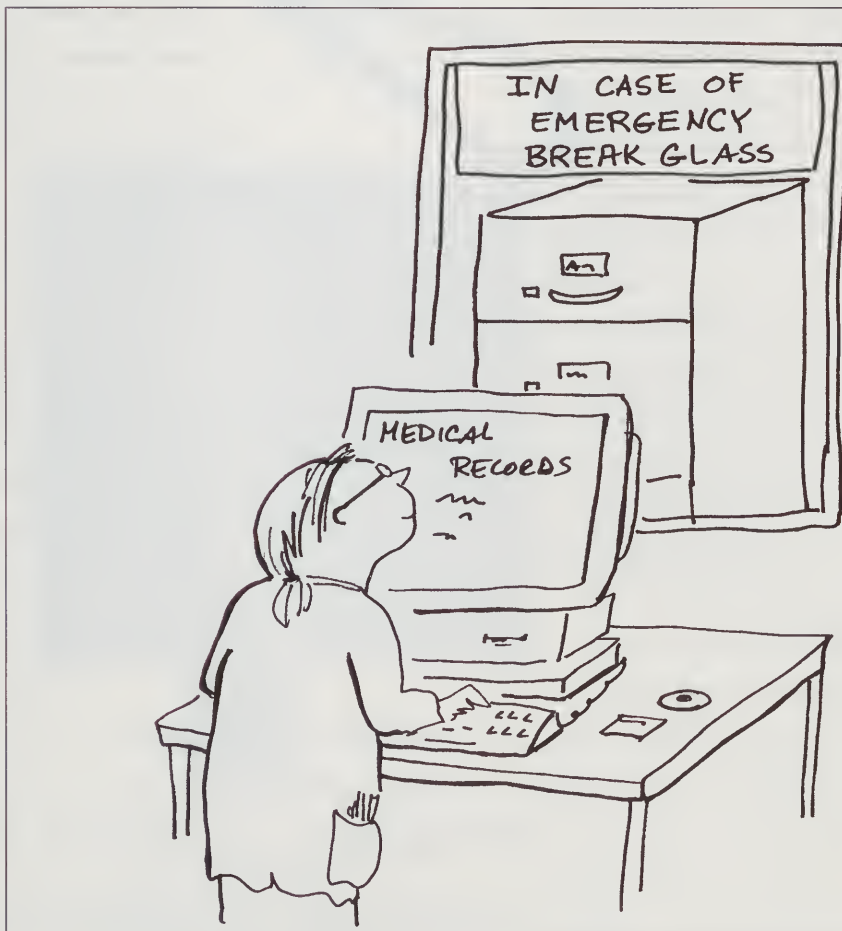
According to findings from the Agency for Health Care Policy and Research (AHCPR) millions of American children still are uninsured and face barriers to receiving medical care. The findings of AHCPR are published in a new sourcebook entitled, *Children's Health 1996*. To obtain a copy, contact the AHCPR Publications Clearinghouse at 800.358.9295 or access the AHCPR web site, at www.ahcpr.gov.

RIVER WALK

The Board of the Atlantic City Medical Center—part of AtlantiCare Health System—has approved an agreement to establish a strategic alliance with the Jefferson Health System. "This alliance complements our partnership with Thomas Jefferson University's pediatric affiliate, duPont Hospital for Children," says **George F. Lynn**, president of AtlantiCare.



George F. Lynn



New Jersey Medicine (ISSN 088-5842-X) is published monthly (since 1904) under the direction of the Council on Communications by the Medical Society of New Jersey (MSNJ), Two Princess Road, Lawrenceville, NJ 08648. Printed in Lancaster, PA, by Lancaster Press. Printed in USA. Whole number of issues 1128. Member's subscription (\$10) is included in MSNJ dues. Rates for nonmembers are \$50; outside USA, add \$20. Single copy is \$7.50. Periodicals postage paid at Trenton, NJ, and Lancaster, PA. Copyright 1998 by MSNJ. June 1998. Internet address: <http://www.msnj.org>. E-mail address: info@msnj.org. 609.896.1766. FAX 609.896.1368. Postmaster: Send address changes to *New Jersey Medicine*, Two Princess Road, Lawrenceville, NJ 08648. The appearance of advertising *New Jersey Medicine* is not a MSNJ guarantee or endorsement of the product or service, by the advertiser. When MSNJ has endorsed a product or program, that will be expressly noted.

When professional health law counsel is called for,
call the firm the experts are calling.



For years health care providers and businesses have been calling Theodosia A. Tamborlane P.C. when they needed accurate information, insightful commentary and practical advice. That's because Theodosia A. Tamborlane P.C. successfully navigates through the maze of government activity at both state and federal levels every day.

Today physicians, hospitals, nursing homes, assisted living, ambulatory care

facilities, home health care agencies and other providers turn to this firm for legal services including managed care contracting and corporate compliance plans. It's little wonder why leading health law publications and the nation's most prestigious legal, medical and business associations keep calling Theodosia A. Tamborlane P.C. to keep their members up to date. When you need professional legal counsel select the firm that knows the issues ...

Theodosia A. Tamborlane, P.C.



THEODOSIA A. TAMBORLANE, P.C.

COUNSELORS AT LAW

1044 ROUTE 22 WEST, MOUNTAINSIDE, NEW JERSEY 07092

908-789-7977

Member, American Medical Association Doctors Advisory Network

Charter Member, American Association of Physician-Hospital Organizations-Integrated Healthcare Delivery Systems

Murder she wrote, and other stories

Jessica Fletcher would have no trouble in pinning guilt on politicians who refuse to believe the scientific evidence regarding needle exchange programs, but I have difficulty in pinpointing those most responsible—there are so many of them. My most recent editorial on this subject, in November 1997, was deliberately scheduled to appear after the elections. At that time I wrote, "The balloting has ended, the rhetoric has lessened, and political correctness for the sake of votes is no longer necessary." How naïve!

We have had many developments since the arrests of the Chai volunteers in New Brunswick. On February 18, 1998, the arrest venue shifted to Perth Amboy, where similar workers had been handing out clean needles since October. The local newspaper, *The Home News Tribune*, said, "Perth Amboy police officers can't be faulted for arresting. . . . They were just following the law . . . the foolish law. . . . The volunteers aren't promoting drug use or condoning evil

lifestyles. They're trying to prevent deaths."

On March 16, the Presidential Advisory Council on HIV/AIDS issued a severe criticism of the Clinton administration's refusal to use federal money for needle-exchange programs. Noting that 33 people were dying daily from dirty needles, the Council urged reconsideration in a letter to Donna A.

Shalala, secretary of Health and Human Services (HHS). "Our patience is exhausted," said Dr. Scott Hill, chair of the Council, who estimated that the needle programs could save tens of thousands of lives. His conclusions were backed by many reports, at least six funded by the government, including one from the National Institutes of Health. Donna Shalala

agreed that the programs were effective and she supported them, but only in theory, and the ban on federal funds would continue.

The New Jersey Governor's Advisory Council on AIDS also convened and asked for reconsideration. As of this writing, Governor Whitman has not changed her stand, although we now rank fifth in the nation in AIDS cases and third in those due to intravenous drug use.

We still have those who deny the effectiveness of these programs. Barry McCaffrey, the head of the national drug policy, and James L. Curtis, a New Yorker who "specializes in addiction," are two of the ones who cite Canadian studies in Vancouver and Montreal as depicting failures in reducing the spread of HIV. However,

Howard D. Slobodien, MD



As the births of living creatures, at first, are ill-shapen, so are all innovations, which are the births of time.

Francis Bacon, *Essays*, "Of Innovations," 1597-1625

Editor's Notes

Professors Julie Bruneau and Martin T. Schecter, who authored the Canadian studies, feel these critics have misinterpreted their reports. They calculate that each of the two cities would need ten million clean needles a year to keep up with the present drug usage. The Vancouver project supplies two million annually, Montreal only one-half million. They also quote a 1997 *Lancet* report on 29 cities worldwide, indicating about a 6 percentage point drop in HIV infection where needle exchange is done, compared to a 6 percent increase in 51 cities without such programs.

The attitude of the Clinton administration is almost schizophrenic—giving strong support to these programs and encouraging their implementation, but forbidding use of government money. Daniel Zingale, executive director of an AIDS advocacy group, complained, "Today's action is like acknowledging the earth is flat but refusing to fund Columbus' voyage." Dr. David Satcher, the surgeon general, said 40 percent of new AIDS cases were due to contaminated needles and in women and children the figure was 75 percent. Yet General McCaffrey says needle programs send the wrong message to children. Let him tell that personally to the infants born with the affliction, and to their mothers! (The Congressional Black Caucus called for the resignation of McCaffrey.)

**The wise know that
foolish legislation is
a rope of sand, which
perishes in the twisting.**

**Ralph Waldo Emerson, *Essays,*
"Politics," 1844**

The *New York Times'* editorial of April 22 suggested the Clinton position represents a "calculated duck" to appease conservatives and avoid more repressive legislation—a move that will not forestall anti-needle exchange bills, but that could cost many, many lives. (Representative Gerald B.H. Solomon, New York Republican heading the House Rules Committee, vowed to pass legislation permanently banning federal payments.)

The mayors of San Francisco, Detroit, Seattle, Baltimore, and New Haven have asked for federal support. Health workers for From Our Streets With Dignity, who distribute needles at Park Avenue and 124th Street in Manhattan, suggested that members of the Clinton team visit them to witness how lives are saved. (From Our Streets With Dignity is only one of nine exchange groups in New York City.) The Chai group, as expected, is disappointed and dumbfounded at this new example of "political cowardice." Ellen Goodman, respected colum-

nist for the *Boston Globe*, headlined, "I was wrong! Needle-exchange programs work." She concluded with: "We know how to slow a lethal epidemic. We know one way to help prevent the spread of HIV from drug addict to partner to child. We just aren't going to do it." Moorestown-born Katherine Shindle, Miss America 1998, is a strong supporter of needle exchange.

The latest data from the Centers for Disease Control and Prevention indicate a recent decline in U.S. AIDS cases, due to more effective medications slowing the change from HIV to AIDS. But "HIV continues its relentless march into and through our population," and the increasing risk to women and minorities has been confirmed.

Even though HHS will not fund the needed needle exchange programs, its endorsement of efforts by other groups is helpful. George Soros, a private philanthropist who helped Chai and has pledged one million dollars in matching funds for nationwide activities, also has retained Dale Florio's Princeton Public Affairs Group to aid in state efforts to obtain legislative, and gubernatorial, approval of needle exchanges.

Let us hope this will result in what is long overdue, protecting the innocent and treating HIV and AIDS as the public health problems they are.

Our doctors aren't just great. They're the best.



Hudson County's best doctors practice at St. Mary Hospital of Hoboken and St. Francis Hospital of Jersey City. With nearly 600 skilled, caring professionals, our medical staff includes a growing number of leading specialists who are nationally-recognized experts in fields like perinatology, internal medicine and psychiatry.

So when you're looking for a doctor, choose the best.
Call (201) 418-2020.

**ST. FRANCIS
HOSPITAL**
of Jersey City

**ST. MARY
HOSPITAL**
of Hoboken

The best doctors and nurses. Right in your neighborhood.™

GATEWAY TO THE NET

Don't be turned off by its "no-frills" appearance.

The Doctor's Directory of Medical Internet Addresses is a White Pages-style of categorized web site addresses of interest to physicians, residents, medical students, nurses, and hospital staff. Authors Michael D. Gainely, MD, and Milton C. Heuston, MBA, MSMS, of Heuston Consulting in Eatontown give a



Milton C. Heuston

superb overview of the Internet and the world wide web, plus their strengths and weakness. A great tool for those just venturing into cyberspace or an excellent reference for those with Internet savvy. To order a copy, call 1.800.576.1241.

Rx: THE INTERNET

Today's health-conscious consumers aren't satisfied leaving the doctor's office



Jennifer Wayne-Doppke

with a prescription in hand. Many want patient education. Point your patients online for more information about their medical condi-

tions and healthy lifestyles. Here are some suggestions from Jennifer Wayne-Doppke, executive editor of *Medicine on the Net*: Healthy Ideas, healthyideas.com; WellnessWeb, www.wellweb.com; Healthtouch Online, www.healthtouch.com; HealthWorld Online, www.healthy.net/; NetWellness, www.netwellness.org; and Put Prevention into Practice, www.hhs.gov/PPIP/.

SIX PICKS

Electronic journals are here to stay. But the paper version isn't obsolete. Today, most medical journals have some presence on the web—from a table of contents and abstracts to the entire, full-text journal. Robert Kiley, MSc, ALA, offers six of the best online medical journals (*Journal of the Royal Society of Medicine*, March 1998). They are: *Annals of Internal Medicine* (www.acponline.org/journals/annals/annaltoc.htm); *British Medical Journal* (www.bmj.com); *The Journal of the American Medical Association* (www.ama-assn.org/public/journals/jama/jamahome.htm); *Journal of Clinical Investigation* (Intl.jci.org); *The Lancet* (www.the-lancet.com/); and *The New England Journal of Medicine* (www.nejm.org/).

BOOKMARKS

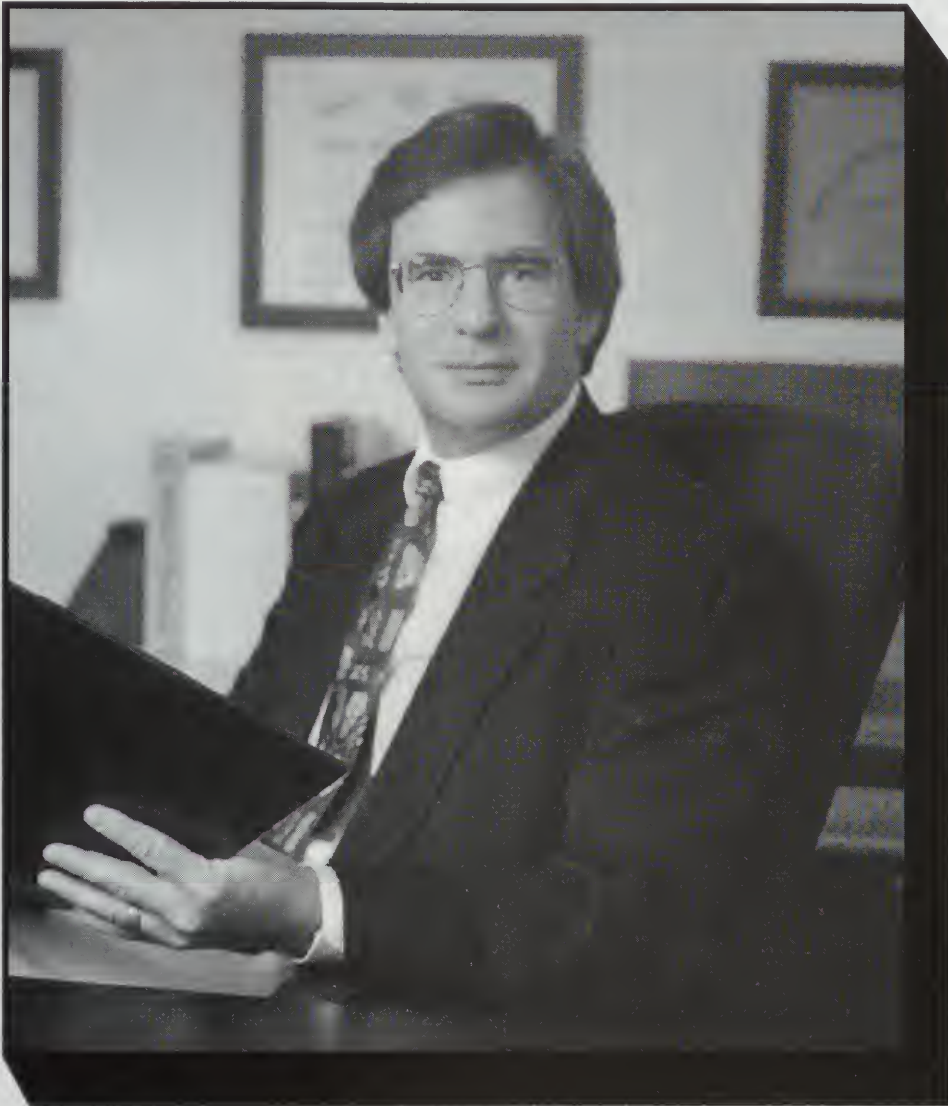
www.njn.net
What's going on at the state's public television station, New Jersey Network? Find out about award-winning programs in health, public affairs, the arts, and education.

www.heartpoint.com/
Take a look at HeartPoint, a high-quality source for patient information on heart disease.

www.artnet.com
ArtNet is a guide to the world of art, including exhibits, museums, and art fairs.

www.certifieddoctor.org
Find a board-certified specialist nationwide at the American Board of Medical Specialties online CertifiedDoctor.

www.os.dhhs.gov/progorg/grantsnindex.html
Looking for grant money? Turn to GrantsNet, by the Department of Health and Human Services.



Stuart M. Hochron, M.D., Esq.

Physician Legal Representation

- Group Practice Formation
- Physician Litigation
- Federal Regulation
- Board of Medical Examiners

Practicing Physician, Twenty Years

Clinical Professor, UMDNJ-RWJMS

Research as Highlighted on CNN

AMA Physician Referral Service

Partner, Richmond, Hochron & Burns



phone: (732) 821-0200 fax: (732) 422-9444 e-mail: MDLAWSMH@aol.com

209 North Center Drive North Brunswick, New Jersey 08902

Direct AccessSM

for small employers

- Visit a specialist
without a referral.

- Nationwide access to over 300,000 participating doctors, specialists and hospitals.

- Value added discounts for you and your employees from Cole Vision and CompUSA.



And, announcing a \$25,000 *life insurance program* for small employer groups that join the MSNJ/BCBSNJ program!

This and more is available when you choose the new Direct Access health plan from Blue Cross and Blue Shield New Jersey—The Medical Society of New Jersey's health carrier of choice for its members!



**BlueCross BlueShield
of New Jersey**



Ask us for a free
copy of the SEH
Buyer's Guide.

For more information on Direct Access, and other
health plans for individuals, families
and small employers,
contact the Medical Society of New Jersey's
exclusive BCBSNJ representative:



Jennifer Altobelli
Sales Representative
973-338-0893

EATING DISORDERS

keeping the plate CLEAN

EATING DISORDERS ARE SERIOUS CONDITIONS THAT ARE HARD TO DIAGNOSE AND EVEN HARDER TO TREAT. PHYSICIANS AND OTHER HEALTH CARE PROFESSIONALS NEED TO TREAT THESE PEOPLE WHO ARE KEEPING THEIR PLATES ALL TOO CLEAN.

By Robin Rapport

When a symptom of an illness is denial, identifying the problem is extremely difficult particularly when the patient may look as normal as anyone else; when laboratory test results may appear normal; and when the physician may be under the increased time constraints of the managed care environment.

Eating disorders, or "abnormal behavior patterns with regard to food," are serious conditions that are hard to diagnose and even harder to treat. Getting the patient to seek help is a major problem. Even with increased awareness of anorexia nervosa and bulimia, victims of

eating disorders rarely contact physicians for treatment.

Nevertheless, primary care physicians, internists, pediatricians, and gynecologists are crucial in identifying the problem. That is because, often, affected patients visit physicians for routine examinations or for symptoms that may—or may not be—related to their eating disorders. Physicians, dentists, and parents identify and refer almost one-half of the eating disorder cases for treatment; the rest generally are school initiated.

"Eating disorders are increasing in frequency and becoming more prevalent across the socioeconomic spectrum,"



reports Robin Boudette, PhD, program director of The Medical Center at Princeton's Eating Disorder Unit. Anorexia nervosa, bulimia nervosa, and binge eating disorders affect more than two million women and men, usually between the ages of 12 and 35 years. According to Boudette, the problem is so widespread that "physicians should assume patients, particularly young females, have a problem. Then ask questions to rule it out." Knowing what to ask and what to look for are keys to early identification, assessment, and successful intervention in these difficult, perplexing, and potentially deadly illnesses.

Anorexia nervosa, self-imposed starvation, is a serious life-threatening disorder stemming from underlying emotional causes. Dangerous medical problems, including damage to the gastrointestinal track, and even death, may result. Although people with anorexia are obsessed with food, they continually deny their hunger. Anorexics often limit or restrict other parts of their lives besides foods, such as relationships, social activities, and/or pleasure.

The exact prevalence of anorexia is unknown since many sufferers

never seek treatment. As many as 1 percent of young women in the U.S. are afflicted. The problem is not limited to females; approximately 5 percent of anorexics in treatment are male.

Anorexia nervosa is more than a mental health problem. According to a report from The Renfrew Center, a national mental health care organization dedicated to the treatment of women and eating disorders, "Twenty percent of women diagnosed with anorexia will die from related (physical) health problems."

Bulimia nervosa is more common than anorexia. The Medical Center at Princeton reports that it may affect up to 25 percent of young adult women. Bulimia nervosa, the repeated cycle of out-of-control eating, followed by some form of purging, can be fatal. The purging may be self-induced vomiting, excessive use of laxatives or diuretics, or obsessive exercising. People with bulimia often feel out of control in

Robin Boudette, PhD



Warning Signs

Specialists at The Renfrew Center advise physicians to be alert to extreme thinness (less than 85 percent of ideal body weight), dry, yellow-tinged skin (caused by hypercarotenemia), abdominal pain, complaints of feeling bloated, constipation, mild hypoglycemia, menstrual disturbances, frequent infections, low resistance, fatigue, complaints of coldness, cardiac abnormalities (sinus bradycardia, systolic blood pressure below 60 mm Hg, mitral valve motion irregularities, midwall shortening, and reduced left ventricular mass), dizziness, and abnormal laboratory test values.

Common signs also may include loss of or thinning hair, dry skin, chest pains, body image distortions, binge eating, frequent use of the bathroom after meals, reacting to emotional stress by eating, swollen glands, frequent weight fluctuations, obsessive concern about weight, failing attempts to diet, enlarged salivary glands, inability to stop eating voluntarily, and red knuckles or scars on the back of hands from using hands or fingers to facilitate regurgitation.

other areas of their lives besides food, such as in controlling money, drugs, alcohol, and/or relationships.

Sometimes, bulimic behavior is seen in anorexics, but bulimia alone does not result in severe weight loss. However, it may cause major gastrointestinal problems, kidney damage, serious potassium depletion, dental and esophageal problems due to the acidic nature of regurgitated food, loss of energy, depression, and even death.

Compulsive overeating, the use of diet pills, laxatives, diuretics, and other dangerous eating/dieting practices are even more widespread. Compulsive overeating causes all the problems associated with obesity, including exacerbation of medical conditions such as diabetes and heart disease. If the compulsive overeating also is a "binge eating disorder," the patient has repeated episodes of uncontrollable binge eating, followed by guilty, shameful feelings without purging. Patients with psychosomatic conditions, such as fear of choking, may suffer from profound weight loss and malnutrition. Patients abusing substances to lose weight suffer from a wide range of additional problems.



Donald E. Erwin, PhD

"Fortunately," says Donald E. Erwin, PhD, Somerset Medical Center's associate medical director of the Eating Disorders Program, "More pediatricians and internists are successfully identifying the problem and making treatment referrals." Still, he urges physicians to refer early and not to wait for significant weight loss or other obvious signs, and to become more attuned to eating disorder thinking and behavior in the making. Determining when thinking and behavior become dangerous is complicated in a culture already obsessed with weight and thinness.

The problem starts early. "I see girls in the second and third grade manifesting signs of eating disorders," observes Lori Posner, MED, a nationally certified counselor in private practice who works with adolescents and lectures in New Jersey schools about body image. Pediatrician Anthony Brickman, MD, adds, "You can't start prevention too early." In his Pennington

practice, he discusses eating issues with parents of infants, advising parents to "stop overfocusing on feeding children and let the children eat. Left to themselves, young children are self-regulating, with the exception of sweet foods." Brickman sees the preoccupation with food intake—whether it is about lack of intake or the reverse—as a blueprint for later problems.

"Doctors who see these kids on a yearly basis have an excellent opportunity to identify these conditions," suggests Posner. "Unfortunately, in today's health care environment, it's difficult for doctors to have sufficient time to adequately access the problem or to notice trends over time. That's why it is vital for physicians to take a minute and ask preventive questions like, 'How do you feel about your body?' and 'What do you like to eat?'"

Posner also warns about a time gap when eating disorders may go undetected, "The time between when girls stop going for routine pediatrician appointments and when they start going for routine gynecological appointments—these are vulnerable years for young adults. Yearly preventive examinations should be continued during this critical time."

In addition, physicians should be alert for patients who diet, even though not overweight; who have a distorted body image; who are pre-

occupied with food, calories, nutrition, or cooking; who deny their hunger; who exercise obsessively; who get weighed frequently; and/or who complain about feeling bloated or nauseated even when eating small amounts of food.

Even when patients exhibit symptoms, physicians face an uphill battle getting appropriate care to eating disorders victims.

Patients may be unaware or deny that there is a problem. Patients may utilize creative ways to disguise their illness—from wearing baggy clothing to hiding weights under their clothes, or to drinking gallons of water to distort their actual weight. Managed care restrictions, limited time with patients, limited choices in referral, and financial constraints of patients also may compromise treatment. In addition, some health plans insist on laboratory data to justify treatment. Unfortunately, for many patients, tests may appear normal—until it is too late.

"Eating disorders are some of the most difficult medical problems to treat because they have so many different causal factors," explains psychiatrist Kenneth W. Willis, MD, medical director of the Eating



Kenneth W. Willis, MD

Disorders Program at The Medical Center at Princeton. "The origins of the problem (biological, psychological, and social), the varied symptoms, the degree to which patients suffer and the uniqueness of each disorder must all be taken into consideration."

First and immediately, the patient's physical condition must be evaluated and stabilized. Urgent medical, psychological, and/or nutritional inpatient treatment may be necessary. This may require emergency treatment or intensive hospital care. Only after patients are

Anthony Brickman, MD



out of life-threatening danger can treatment begin on the underlying causes of the illness, on coping skills, on development of healthy eating habits, on self-esteem and body image issues, and/or on the depression, anxiety, trauma, or mood disorders that may accompany the eating disorder.

Today, a variety of treatment modalities is available, including inpatient treatment, partial hospitalization, intensive outpatient care, medication treatment, and outpatient services. Eating disorder patients often benefit from individual, group, and/or family therapy. Support groups and continued after-care also help patients toward recovery.

Most experts agree that treating eating disorders requires a comprehensive, multidisciplinary approach handled by specialists. The treatment team may include a medical director, board certified psychiatrists with a specialty in eating disorders, physicians (cardiologists, gastroenterologists, and others), psychologists, psychiatric nurses, nutritionists, social workers, and occupational, physical, and activity therapists.

Recovery is a long-term process that depends largely on motivation and type of treatment. Even when caught early in a cooperative patient, recovery can take a minimum of two years, plus a lifetime of dealing with the illness.

Our idea of a small business loan is anything but small.

Your small business loan is a big deal to us.

Valley National makes Small Business Administration (SBA) Loans for as little as \$50,000. Or as much as \$1,000,000. We're a Preferred SBA lender, so the approval process is amazingly quick. In most cases, initial credit approval takes three business days or less.

According to the U.S. Small Business Administration, you'll be working with the #1 SBA Lender in New Jersey for 1997. Our team of experts specializes in satisfying the needs of small businesses. And you'll find the monthly payments are surprisingly affordable. If you borrow to finance your commercial property, you'll have up to 25 years to pay it back. Borrow to finance equipment or working capital and you'll have up to 15 years or up to 7 years respectively, to repay. So give us a call. Helping to grow your business is our business.

1-800-SBA-6772

Valley National Bank

Member Federal Reserve System. Member FDIC.

An Equal Opportunity Lender. Preferred SBA Lender.

THE BANK THAT WORKS.SM

www.valleynationalbank.com

NORTH ARLINGTON NORTH CALDWELL NORTH PLAINFIELD

NORTHVALE NUTLEY OAKLAND ORADELL PARAMUS

FRANKLIN FREEHOLD FORT LEE GREEN BROOK HACKENSACK HACKENSACK HARRISON HILLSDALE HO-HO-KUS JEFFERSON TOWNSHIP KEARNY LAUREL LITTLE FALLS LIVINGSTON LYNDHURST MARLBOROUGH MIDLAND PARK MILNE HILL MONMOUTH MORRIS PLAINS NEW MILFORD NEWARK

© 1998 Valley National Bank

Medical Society of New Jersey

Long Term Care Insurance Program

Ensuring a Secure Future by Preserving Assets

As medical professionals, you know first hand the devastating effects that extended long term care can have on a person's hard earned assets. The cost of nursing home stays can range from \$3,000-\$5,000 per month. The Medical Society of New Jersey endorses The Travelers and CNA Insurance Companies' policies to help you guard against unforeseen tragedies. Through a special arrangement with The Travelers and CNA Insurance Companies, members, spouses, parents and in-laws are eligible for a premium reduction.

IMPORTANT FEATURES OF THE MSNJ ENDORSED LONG TERM CARE INSURANCE PROGRAM

- ◆ Available Ages 45-84
- ◆ Specialty Plans Available Ages 80-100
- ◆ Benefits up to \$250/day
- ◆ No prior hospitalization required
- ◆ Several waiting periods
- ◆ Alzheimer's, senility covered
- ◆ Lifetime benefits available
- ◆ Guaranteed renewable for life
- ◆ Coverage for custodial, skilled and intermediate care as well as adult day care
- ◆ Available to your spouse, parents and in-laws
- ◆ Waiver of premium benefit
- ◆ Inflation protection available

DISCOUNT FOR MEMBERS OF MSNJ, SPOUSES, PARENTS AND IN-LAWS

For more information, please call

DONALD F. SMITH & ASSOCIATES

A division of THE COPELAND COMPANIES[®]

Two Tower Center, P.O. Box 1063
East Brunswick, New Jersey 08816-1063

(888) 297-7225

Copeland Associates, Inc.

Medical Society of New Jersey
MSNJ

GME THE CHALLENGE OF GRADUATE MEDICAL EDUCATION

GME PLAYS A MAJOR ROLE IN ACADEMIC MEDICINE AND IN THE HEALTH POLICY DEBATE.

CRITICAL ISSUES IN GRADUATE MEDICAL EDUCATION ARE SHAPING UP. THE

CONTROVERSY CENTERS AROUND FUNDING OF GME AND PHYSICIAN WORKFORCE

REQUIREMENTS. READ ABOUT WHERE THE DEBATE IS HEADED.

By Stanley S. Bergen, Jr, MD; Vivian H. Lubin, MBA, MPH; Sheila Eder, PhD

Graduate medical education (GME) is a major focus of academic medicine.

GME also plays a prominent role in the health policy debate, as demonstrated by the multiple GME-related provisions of the recently enacted federal Balanced Budget Act (BBA) of 1997. Two main forces have driven GME to the forefront nationally: future physician workforce requirements and financing for GME.

FUTURE PHYSICIAN WORKFORCE REQUIREMENTS

The number of physicians needed and the mix of primary and specialty care physicians have been studied and debated since the early 1990s. In 1997, six major national medical and medical education associations issued a consensus statement acknowledging a serious physician oversupply and identifying GME reform as the mechanism to address the imbalance. GME was targeted for a simple reason: the number of first-year residency positions in the United States represents approximately

135 percent of the graduates of American medical schools. In large part, this difference is attributable to international medical graduates (IMGs) completing the postgraduate phase of their medical education in the United States. To reduce physician oversupply, capping the number of first-year residency slots at 110 percent of the number of graduates of U.S. medical schools has been proposed; a 50-50 mix of primary care (internal medicine, family practice, and general pediatrics) to specialty residency programs also has been recommended.

FINANCING FOR GME

Traditionally, Medicare has provided the majority of funding for GME; Medicare cuts in the BBA will have a profound effect on teaching hospitals. The reimbursement methodology for direct GME (DGME)—stipends and fringe benefits for residents and supervising faculty and associated costs—is being revised, capping the number of allopathic and osteopathic residents used in the calculations. The methodology for indirect medical education (IME)—less tangible factors that contribute to higher patient care costs in the academic setting—also was adjusted significantly to lessen costs. The IME adjustment, an add-on to the Medicare diagnosis related group (DRG) rates, will be reduced from

Table 1. Number and percent in primary care* residency programs: New Jersey data compared to national data, 1994-1996.

	National		New Jersey	
	Number	Percent	Number	Percent
1994	37,538	40.1	1,441	55.8
1995	38,753	40.7	1,466	56.8
1996	40,265	41.1	1,442	57.0

*Primary care is defined as internal medicine, family practice, pediatrics, and combined medicine/pediatrics.

The comparison is limited to allopathic accredited programs. The comparison between New Jersey and national data for all specialties in 1994 and 1995 is reported in the AGMEC *Summary Report: Graduate Medical Education Survey 1996-1997*. The New Jersey data for 1996 also are presented in that report. National data for 1996 were published in *JAMA*, 1997; 278:750-754, U.S. Graduate Medical Education, 1996-1997. © 1997, American Medical Association.

7.7 percent for every 10 percent increment in a hospital's resident-to-bed ratio, to 5.5 percent in 2001 and beyond.

While funding reductions are likely to encourage residency downsizing, the BBA also establishes a

SHOULD WE CAP THE
NUMBER OF FIRST-YEAR
RESIDENCY SLOTS AT 110
PERCENT OF THE NUMBER
OF U.S. MEDICAL SCHOOL
GRADUATES?

nationwide demonstration project, modeled after a program approved earlier last year in New York, intended to reduce the number of residents by 20 to 25 percent. A "hold harmless" provision phases the loss of Medicare GME payments to hospitals over five years. While the program is a voluntary one, it indicates a clear direction on the part of the federal government to reduce physician supply and slow the growth of GME spending.

The issues being addressed in the national debate are familiar ones in New Jersey, a national leader in recognizing the need for GME planning and oversight. In 1978, the Advisory Graduate Medical Educa-

tion Council (AGMEC), a broadly representative council of GME stakeholders, was created by the New Jersey Legislature to "establish, foster, enhance, and monitor GME in New Jersey. . . . The purpose of the Council is to make recommendations for the support, through federal, state, and private funds, of GME programs in nonprofit and public hospitals in the state of New Jersey, and to make recommendations for the development and implementation of new GME programs that will meet the needs of the citizens of the state."

Over the years, AGMEC's initiatives have included the GME program seed grants, which, between 1979 and 1986, provided over \$1.5 million to 24 New Jersey hospitals and over 29 separate residency pro-



grams. AGMEC assisted in the development of five family practice programs, expanded programs in general pediatrics and general internal medicine, and introduced training components for psychiatry and geriatric medicine within internal medicine residencies. GME programs located in inner city and rural

areas received priority for the grants.

In 1984, AGMEC developed "A Policy Prospectus for GME in New Jersey," which defined two major areas of focus: scope and quality, and financing. Consistent with these emphases, AGMEC, working with the New Jersey Department of Health and Senior Services, implemented procedures to review hospital requests to expand or modify GME programs, stressing quality and relevance. New programs or program growth were approved only in such areas of need as primary care, infectious diseases, and geriatric medicine, for example. With the deregulation of the hospital payment system in New Jersey in 1993, state funding for GME ceased, save for a limited amount included in Medicaid reimbursement rates. AGMEC supported and participated in the development of a joint teaching hospital forum of the state's 44 teaching hospitals, to provide statewide advocacy for GME. AGMEC has provided professional and technical input to the joint forum in establishing a goal of a statewide reduction in residents of more than 25 percent.

AGMEC also has developed an annual reporting mechanism and a comprehensive database of some 14,030 individual physicians who

Table 2. Percent of international medical graduates: New Jersey data compared to national data, 1994-1996.

	National		New Jersey	
	Number	Percent	Number	Percent
1994	22,404	23.9	1,525	59.1
1995	24,206	25.4	1,488	57.7
1996	24,703	25.2	1,441	57.1

The comparison is limited to allopathic accredited programs. The national totals for 1994 and 1995 are reported by permission of the AMA in the AGMEC *Summary Report: Graduate Medical Education Survey 1996-1997*. National data for 1996 were published in *JAMA*, September 3, 1997. Osteopathic training programs accept no foreign-trained physicians. *JAMA* 1997; 278:750-754, U.S. Graduate Medical Education, 1996-1997. © 1997, American Medical Association.

served residencies in the state since 1984. The database includes such variables as demographic characteristics, medical school attended, the year of graduation, and all GME placements in New Jersey. AGMEC issues an annual report on the survey findings and is beginning to broaden the scope of the report to include time trends by specialty of program and comparisons between New Jersey and American Medical Association (AMA)-reported national data on GME.

The data reported by the AMA for accredited allopathic residencies reveal that New Jersey compares favorably with the nation in terms of the growth in GME in recent years. Between 1995 and 1996, the number of residents in New Jersey in accredited allopathic programs declined by 2.3 percent, as compared with an increase nationally of 3.1 percent. (The overall decrease in New Jersey GME is less than 2 percent due to an increase in the number of osteopathic interns and residents.)

The percent of New Jersey allopathic residents in the primary care disciplines is more than twice the national average and is well beyond

the 50 percent target (Table 1). However, New Jersey leads the nation in the percent of residencies filled by IMGs (Table 2). In comparison with AMA data from accredited allopathic programs, the percent of IMGs in New Jersey is more than twice that reported nationally. Even though osteopathic programs do not accept foreign-trained physicians, when the 300 osteopathic trainees in New Jersey are added to the data in Table 2, the percent of IMGs exceeded 50 percent.

The AGMEC database is a rich resource to the state, its teaching hospitals, and the medical schools of UMDNJ in planning and implementing future GME directions; the database provides information on a number of potential criteria for GME resizing suggested in an October 1997 report published by the Association of American

Medical Colleges (AAMC), *Reaching Informed Institutional Decisions about GME Program Size*, such as the training program's "competitive status" and recruitment record, career paths of program graduates, and the relative proportion of U.S. graduates in the program compared with the national proportion for that specialty. Also included in this AAMC report is a case study of the innovative approach to ensuring consistency between the number of residents and the demand for physicians being utilized at UMDNJ-Robert Wood Johnson Medical School. The program, which the school has not yet needed to implement, commits it to employ graduating residents who are unable to find suitable employment, with a commensurate reduction of the number of residents in that specialty. UMDNJ-New Jersey Medical School and the UMDNJ-School of Osteopathic Medicine also have implemented programs to reduce residents and increase the proportion entering primary care. This will be an ongoing effort as UMDNJ assesses the challenges and opportunities for GME. ■

Dr. Bergen is president, UMDNJ, and chair, Advisory Graduate Medical Education Council. Ms. Lubin is vice-president for planning, UMDNJ. Dr. Eder is director of Institutional Research, UMDNJ.

**THE PERCENT OF NEW
JERSEY ALLOPATHIC
RESIDENTS IN THE PRIMARY
CARE DISCIPLINES IS
MORE THAN TWICE THE
NATIONAL AVERAGE.**

We know that practicing medicine is your primary concern.

The professionals at Healthcare Management Partners will take away the time-consuming administration and pressures of billing, collections, follow-up, office management, and system maintenance, so you can concentrate on doing what you do best - practicing medicine.

Contact Rosalie Fox or Robert Rahl at 609-734-0443 to find out more.

**Practice Assessments • Billing & Collection •
MIS Systems • Group Practice Formation •
Practice Management • Income Distribution**

**Endorsed Computerized Billing,
Accounts Receivable and
Information Management Company of the
Medical Society of New Jersey**



HEALTHCARE MANAGEMENT PARTNERS

PARTNERS IN PROFIT

200 Canal Pointe Boulevard • Princeton, NJ 08540-5998
609-734-0443 • FAX 609-243-9799

A Division of Health Information Consulting Services, Inc.

LIPOSUCTION

BE CAREFUL IN THERE!

IT HAS REVOLUTIONIZED COSMETIC SURGERY MORE PROFOUNDLY THAN ANY OTHER SURGICAL TECHNIQUE THIS CENTURY. WHEN LIPOSUCTION IS PERFORMED PROPERLY, THE RESULTS CAN BE DRAMATIC. THE POPULARITY OF THE PROCEDURE ATTESTS TO ITS BENEFITS, AS POUNDS OF FAT CAN BE SUCTIONED, LEAVING FEW SCARS.

By Arthur W. Perry, MD

Liposuction, the removal of fat through small incisions, had its genesis in Europe in the late 1970s and took the United States by storm in the early 1980s.¹ It rapidly became the most popular cosmetic surgical procedure despite a tide of bad publicity following a flurry of early deaths. By the middle of that decade, liposuction had become a basic procedure included in plastic surgery resident training.² In the last year, however, after at least seven deaths in the United

States, liposuction again was spotlighted in the print and television tabloids.

Liposuction, also called lipoplasty, suction-assisted lipectomy, and liposculpture, is the most common aesthetic procedure performed

in aesthetic plastic surgery. Over 100,000 liposuction procedures were performed in 1996.

Although the procedure involves very small skin incisions, there is a considerable amount of disruption of the subcutaneous tissue. Fat is

mechanically broken up and removed with cannulae, which are connected via wide bore tubing to a vacuum pump creating minus one atmosphere of pressure.

Early problems of injury to blood



Preoperative and postoperative photographs attest to the benefits of liposuction.

els and nerves were solved with introduction of blunt cannulae the holes placed back from the . Similar to the injury seen in a , liposuction caused a tremendous amount of swelling, resulting in third spacing. Fluid and electrolyte problems abounded, as well as problems with acute blood loss. There were cases of necrotizing cellulitis due to inadequate sterilization of the hollow cannulae. The American Society of Plastic and Reconstructive Surgeons set up an advisory committee in 1983 to standardize the technique. By 1985, it was generally accepted to suction no more than two liters of fat.³ Beyond that, the likelihood of significant fluid and electrolyte shifts and blood loss was too great. In the early days, the procedure was indicated only for discrete deposits of fat in non-obese individuals. An age cutoff of 40 years was standard, to decrease the likelihood of overstretched skin not healing postoperatively.

In the late 1980s, surgeons began injecting a solution of lidocaine and epinephrine into the areas prior to suctioning (wet technique). This resulted in a dramatic decrease in blood loss and a shortening of the period of swelling from three months to six weeks.

In the early 1990s, physicians began injecting large quantities of

dilute anesthetic solution (tumescent technique) into the areas to be suctioned.⁴ In addition to achieving a decrease in blood loss, these techniques were performed largely by those operating in their offices, often without the aid of an anesthesiologist. Local anesthetic procedures were the only method of performing these procedures in informal operating rooms, often by non-plastic surgeons.⁵

The combination of the tumescent technique and the use of multiple incisions with smaller tubes (cannulae), brought the procedure into an era of incredible popularity. Relatively few complications occurred and patients were generally pleased with the results.⁶ The refinements in technique extended the indications for the procedure to nondiscrete fat deposits such as the circumferential thighs, calves, and arms. Because of the great decrease in blood loss with the tumescent

technique, the margin of safety in suctioning larger volumes increased.⁷ Plastic surgeons began to increase the amounts of fat suctioned; 2 liters became 3 liters and 3 liters became 5 liters and then became 10 liters.⁸



Over the past few years, a number of deaths were reported in the media; many occurred in patients that had

either high volume suction or high volumes of anesthetic injected. Most deaths occurred in office operating rooms.

BENEFITS AND COMPLICATIONS

The popularity of liposuction attests to its benefits. Through a procedure that leaves few scars, pounds of fat can be suctioned, allowing exposure of body parts in bathing suits or less. The overall complication rate is very low and the satisfaction rate is exceedingly high.^{6,9} As with any aesthetic surgical procedure, the complication rate must be very low in order for the public to undergo the operation. Since there is no disease to treat or true deformity to correct, tolerance for problems is low.

**LIPOSUCTION IS THE MOST
COMMON AESTHETIC
PROCEDURE PERFORMED
IN AESTHETIC PLASTIC
SURGERY; NOTABLY, OVER
100,000 PROCEDURES.**

While complications are generally few in number, their incidence may be rising.^{3,6,10,11} Although the Physicians' Desk

Reference states that the toxic dose of lidocaine is 7 mg/kg when epinephrine is added, physicians have begun to use much larger total doses of lidocaine in large volume suctioning.¹²

Doses of 30-40 mg/kg are being used by some physicians. This dose appears to be safe in many patients.⁴ This large amount of lidocaine is tolerated in most people because it is placed in extremely dilute concentration. Typically, 250 mg of lidocaine is added to each liter of fluid that is administered. The lidocaine blood levels do not peak until 10 to 12 hours after the procedure. The large volume of fluid assures a steady diuresis, keeping the blood levels within safe limits.⁸ If, however, the patient becomes nauseated and intravascularly volume depleted, then there is the chance for a continuing buildup of lidocaine and its metabolites, possibly resulting in toxicity. This can manifest in



Arthur W. Perry, MD

seizures and cardiac and respiratory arrest.¹³

Blood loss is a potential problem with any liposuction.¹⁴ If a large blood vessel is interrupted or if the patient has a coagulopathy, the results could be disastrous. Volume depletion can occur in or if inadequate fluid is given to compensate for the third spacing. Hypovolemic shock may result. Conversely, as the injected fluid is absorbed by the body, intravascular overload and pulmonary edema may result.¹⁵

Deep vein thromboses are possible, particularly in the scenario of Virchow's triad: intravascular volume depletion, direct trauma to the vessels (from the cannulae), and a hypercoagulable state, such as that caused by birth control pills. Pulmonary emboli and death can result.

Intra-abdominal penetration is a rapidly rising complication. Every

organ in the chest, abdomen, and pelvis, has been speared by a wayward liposuction cannula.¹⁶ Hernia is particularly likely to be penetrated.

Infection is a rare complication because of the closed technique. When it does happen, however, the results can be disastrous since as large as 30 percent of the body may have been disrupted.

There also are many aesthetic complications that may occur including rippling, waviness, and dimpling of the skin, skin necrosis, seromas, inadequate or overzealous fat resection, and hanging skin.

ULTRASONIC LIPOSUCTION

In 1996, ultrasonic liposuction was introduced.¹⁷ With this technique, the fat cells are destroyed by ultrasonic energy and the fat then suctioned out. The ultrasonic energy is delivered either through a wound or through the surface of intact skin. The manual labor is reduced but there remains a question as to whether this new technique has any real advantages over the now mainstream tumescent technique. The downside of the technique includes seromas, skin loss due to heat, increased operative time, and the requirement for longer incisions. Long-term effects of organ exposure to ultrasonic energy has not yet been determined.

le the jury is out concerning
e issues, the procedure is being
ormed. This may be due to the
ue nature of cosmetic surgery.
his is a field where new proce-
es often are announced on the
ing news, as opposed to peer-
ewed journals. Randomized
rolled, double-blind studies are
in this area of medicine. Often
results and complications are
known for years after the proce-
e is performed.¹⁸

REFERENCES

Illouz YG: Une nouvelle tech-
ue pour les lipodystrophies
lisses. *Rev Chir Esthet* 4:19, 1980.
Mladick RA, et al.: Sixteen
nths' experience with the Illouz
echnique of lipolysis. *Ann Plas Surg*
20:234, 1986.
Teimourian B, et al.: A
onal survey of complications
siciated with suction lipectomy: A
comparative study. *Plas Reconst Surg*
3:628-631, 1989.
Klein JA: Tumescant tech-
ue for local anesthesia improves
safety in large-volume liposuction.
Pl Reconst Surg 92:1085-1098, 1993.
Klein JA: Anesthesia for lipo-
suction in dermatologic surgery. *J*
Dermatol Surg Oncol 14:1124-1132,
1988.

6. Dillerud E: Suction lipoplas-
ty: A report on complications,
undesired results, and patient satis-
faction based on 3,511 procedures.
Plas Reconst Surg 88:239-246, 1991.
7. Courtiss EH, et al.: Large vol-
ume suction lipectomy: An analysis
of 108 patients. *Plas Reconst Surg*
89:1068-1079, 1992.
8. Rohrich RJ, et al.: The role of
subcutaneous infiltration in suc-
tion-assisted lipoplasty: A review.
Plas Reconst Surg 99:514-519, 1997.
9. Borah G, Rankin M, Perry A,
Wey P: Quality of life outcomes
after cosmetic surgery. Presented at
annual meeting of the American
Society of Aesthetic Plastic Surgery,
1997.
10. Fodor PB: Wetting solutions
in aspirative lipoplasty: A plea for
safety in liposuction. *Aesthetic Plas Surg*
19:379-380, 1995.
11. Grazer FM, et al.: Compli-
cations of the tumescent formula for
liposuction. *Plas Reconst Surg* 100:
1893-1896, 1997.

12. *Physicians' Desk Reference*.
Oradell, NJ, Medical Economics
Co., 1997.
13. Mantz J, et al.: Intraoper-
ative cardiac arrest in a young
woman undergoing liposuction. *Crit*
Care Med 19:304-305, 1991.
14. Samdal F, Amland PF, Bugge
JF: Blood loss during suction-
assisted lipectomy with large volumes
of dilute adrenaline. *Scand J Plas*
Reconst Surg Hand Surg 29:161-165,
1995.
15. Gilliland MD, Coates N:
Tumescent liposuction complicated
by pulmonary edema. *Plas Reconst Surg*
99:215-219, 1997.
16. Ovreb KK, Grong K,
Vindenes H: Small intestinal per-
formation and peritonitis after
abdominal suction lipoplasty. *Ann*
Plas Surg 38:642-644, 1997.
17. Zocchi ML: Ultrasonic assist-
ed lipoplasty. Technical refinements
and clinical evaluations. *Clinics Plas*
Surg 23:551-572, 1996.
18. Illouz YG: History and cur-
rent concepts of lipoplasty. *Clin Plas*
Surg 23:721-730, 1996.

IN THE EARLY DAYS, THE
PROCEDURE WAS
INDICATED ONLY FOR
DISCRETE DEPOSITS OF FAT
IN NON-OBESE PATIENTS
OVER THE AGE OF 40.

Dr. Perry is a clinical associate professor of
plastic surgery, UMDNJ-Robert Wood
Johnson Medical School, and a clinical associ-
ate in plastic surgery at the University of
Pennsylvania School of Medicine. A board cer-
tified plastic surgeon, Perry is a member of the
MSNJ Council on Communications.

Practicing medicine
= good

Practicing running
a business
≠ good

*Practice management and
practice efficiency solutions
from professionals with
hands-on experience*

WITHUM, SMITH & BROWN

Certified Public Accountants & Consultants

Health Services Department

100 Overlook Center

Princeton, NJ 08540

609-520-1188

<http://www.withum.com>

Offices in New Jersey and Pennsylvania



MEMBER NEXIA INTERNATIONAL
A WORLDWIDE NETWORK OF
INDEPENDENT ACCOUNTING FIRMS



THE RIGHT PRESCRIPTION FOR YOUR CALLERS



Message-On-Hold Systems

Use your telephone music-on-hold feature to

- Promote Services*
- Reassure Callers*
- Educate & Inform*
- Encourage Referrals*

HOLD COM

Serving the NJ Healthcare Industry Since 1987

Call 1-800-666-6465

<http://www.holdcom.com>

LIFSHUTZ, POLLAND & ASSOCIATES, P.C.

**THE LAW FIRM THAT SPECIALIZES IN HEALTH
CARE REPRESENTATION OF PHYSICIANS AND
OTHER HEALTH CARE PROFESSIONALS.**

OUR AREAS OF EXPERTISE INCLUDE:

1. Managed Care Contracts with MSOs and HMOs.
2. Health Care Mergers/Joint Ventures/Acquisitions.
3. Development and implementation of Compliance Audits and Plans.
4. Respresentations in Board of Medical Examiner Cases.
5. Asset Protection/Estate Planning as protection against malpractice suits.
6. Federal and State Anti-Kickbacks/Stark/Safe Harbor representation.
7. Medicare/Medicaid/Third Part Audits

**OUR EXPERT STAFF CONSISTS OF SPECIALIZED
ATTORNEYS AS WELL AS PHYSICIAN-ATTORNEYS.**

LIFSHUTZ, POLLAND & ASSOCIATES, P.C.
ATTORNEYS AT LAW

326 LAFAYETTE AVE., HAWTHORNE, NJ 07506
(201) 427-2040

675 THIRD AVENUE, NEW YORK, NY 10017
(212) 949-8484

Web: Lifshutz-Polland.com

THE EFFECTS OF DHEA

By Michael H. Goldman, MD; Nina Logvinenko, MD

D ehydroepiandrosterone (DHEA) has been popularized in the scientific and popular press as a potential fountain of youth. Its reported preventive and therapeutic effects include decreasing cardiovascular mortality, immunostimulation, and improved physiologic and psychological well-being. Unfortunately, side effects of its use are less widely known and include hyperandrogenism and hyperestrogenism, decreased HDL cholesterol level, and hirsutism. This article details a previously unreported complication: hyperprolactinemia.

A healthy 69-year-old white male with no prior serious illness and normal physical findings began taking 100 mg per day of DHEA after reading of its attributes in the press. After three months of taking DHEA, he was advised by a medical colleague to have hormone tests (Table). After finding elevated estrogen and prolactin levels, the patient was advised to stop taking the preparation. He continued to use DHEA and repeated his hormone studies nine months later. After finding both levels elevated again, he consented to stop its usage and when retested one month later, the prolactin and estrogen levels had normalized. The patient noted no positive or negative effects of the

DHEA and his physical examination remained normal.

DHEA is a precursor hormone in the synthesis of estrogen and testosterone. It is produced in the adrenal glands and ovaries. Over time, its production rate decreases. By age 60, its level is 80 percent reduced.

Because of its progressive decline throughout life, DHEA supplements have been thought to be a logical therapy in the prevention, or delay, of human aging. Unfortunately, complications of DHEA can occur, although rarely emphasized. There are reports of a ninefold increase in testosterone levels and a twofold increase in estrogen levels following 1,600 mg a day dosage of DHEA in postmenopausal women. At lower doses (50 mg a day), androgens levels were elevated, while estrogens levels remained statistically unchanged. Androstendione levels were significantly raised in men. Adverse consequences of DHEA also include

decreased HDL cholesterol levels, insulin resistance, and increased facial hair.

Hyperprolactinemia now has been documented as an additional unreported consequence of DHEA usage. It is well known that estrogen levels modulate the secretion of prolactin; pregnant women, for example, have significantly elevated levels. The raised estrogen levels (secondary to DHEA) in this patient were the likely stimulus for prolactin hypersecretion. Its normalization after discontinuing DHEA (with the simultaneous decrease of the estrogen level) helps to support the hypothesis.

The risk and benefit of any pharmacologically active substance should be analyzed carefully before encouraging use.

Drs. Goldman and Logvinenko are affiliated with Englewood Hospital Medical Center. References are available.

Table. Results of hormonal tests.			
	On DHEA		Off DHEA
	3 months	12 months	1 month
Prolactin (3-16 meq/l)	23.5	19.8	6.5
Estradiol (0-50 ng/l)	82	60	19
Luteinizing hormone (2.4-5.9 u/l)	4.7	—	—
Follicle stimulating hormone (.9-15 u/l)	4.2	—	—
DHEA (160-700 ng/dl)	258	—	—
Testosterone (300-990 ng/dl)	516	—	—
Normal values given in parentheses.			

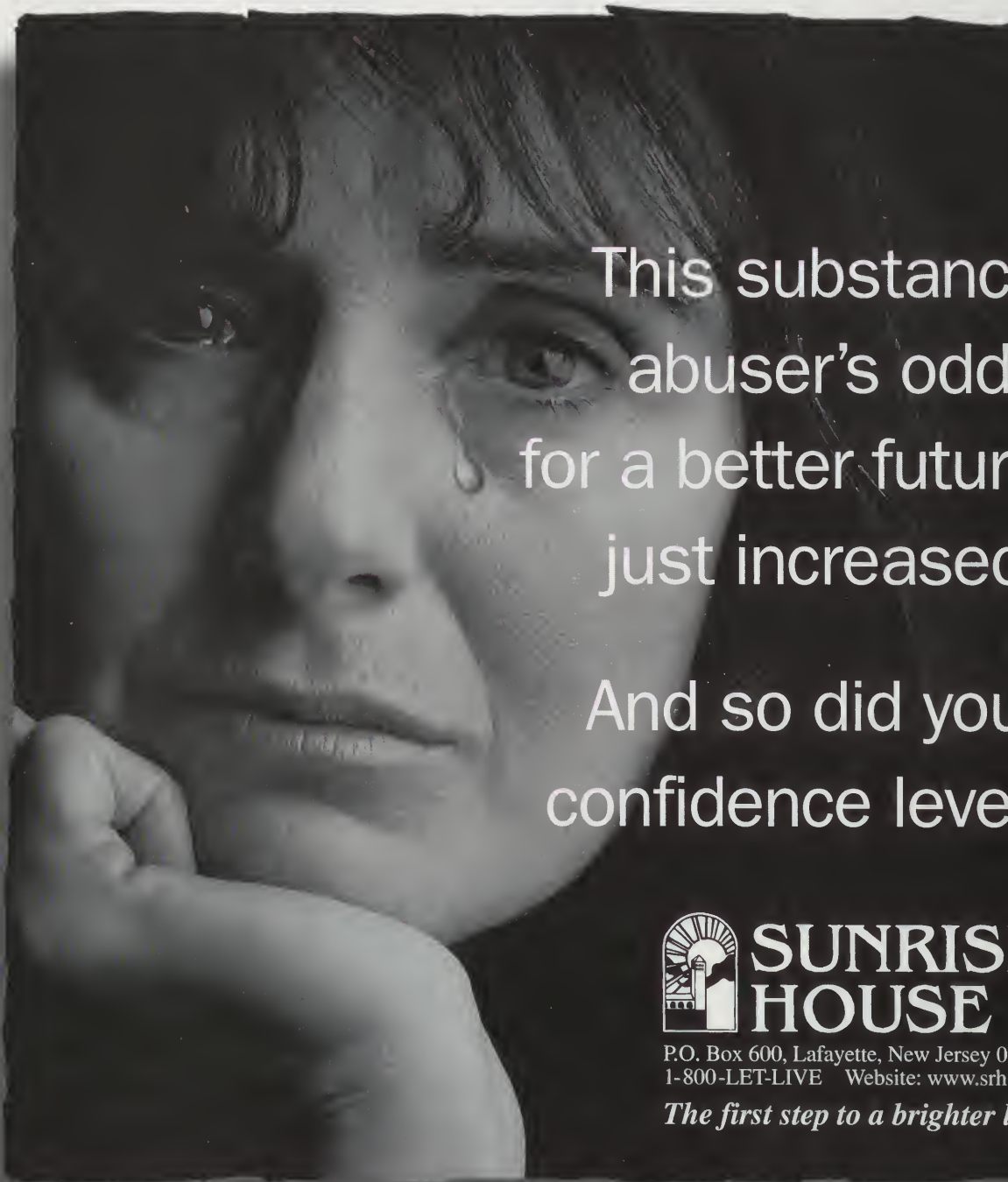
Whether it's an alcohol or drug problem, count on Sunrise House for expert help.

For 14 years, hundreds of tri-state area doctors have trusted us to offer their patients the most effective, caring treatment and a chance for a better life.

Set in the scenic hills of northwest New Jersey, we're a licensed, nonprofit specialty hospital with a nationally known commitment to quality—including Accreditation with Commendation by the JCAHO. Our comprehensive programs include inpatient and outpatient services, after-care and family support.

And our experienced staff of doctors and specialists works closely with referring physicians to ensure continuity of care at every stage of treatment.

Sunrise House. High-quality, affordable treatment you can trust. For information, call us at 1-800-LET-LIVE or (973) 383-6300.



This substance
abuser's odds
for a better future
just increased.

And so did your
confidence level.



**SUNRISE
HOUSE**

P.O. Box 600, Lafayette, New Jersey 07848
1-800-LET-LIVE Website: www.srh.com

The first step to a brighter life.

Sunrise House is a preferred provider of most major insurance companies and HMOs.
We will process insurance benefits verification and precertification.

R. GREGORY SACHS

The NEW JERSEY MEDICINE Interview

A CARDIOLOGIST FROM SUMMIT, R. GREGORY SACHS, MD, TAKES OVER THE HELM OF THE MEDICAL SOCIETY OF NEW JERSEY. FACING CHALLENGES FROM MANAGED CARE AND LEGISLATORS, AND IN OTHER ARENAS, SACHS OFFERS HIS UPFRONT AND NO-NONSENSE APPROACH TO THE FORMIDABLE TASKS PHYSICIANS FACE IN TODAY'S MEDICAL WORLD. AS HE BEGINS HIS TENURE, SACHS PRESENTS HIS VIEWPOINTS TO THE HEALTH CARE COMMUNITY.

By Bill Berlin, PhD

Q. How would you describe the state of the medical profession in New Jersey?

A. I would say that the profession is beleaguered by administrative hassles and the restrictions of managed care and Medicare. MSNJ has the capacity to deal with state issues, but we have to deal with Medicare basically through the AMA. We give them good advice, but we're always one step removed from what can be accomplished there. I would say that our biggest priority in the state is the terribly

slow payments from managed care companies. They almost seem to be using any excuse possible to delay or hold back payments.

Q. How can you deal with this?

A. I think it requires a combination of administrative and

legislative action. We are going to have to put more of the burden on insurance companies that deny claims. Right now, it's the easiest thing in the world for them to say that they don't have enough information and, thus, not pay a claim. One thing that can be done is to require the companies to categorize claims and pay them according to the extent of the information provided. Then, we should require the insurance companies to contract with auditing firms that would run spot reviews of how claims were handled on particular days. If the claims are handled well according to the categories created, then the company gets a nice rating. If not, it gets reported to the commissioner.

Q. Some would say that the last two years have been a period of considerable accomplishment in



R. Gregory Sachs, MD

In the Spotlight

terms of health care policy in the state. Would you agree?

A. Most of the things we've pushed for have been basically patient related. I think one of the last things we have to push for in terms of the patient is making managed care companies liable if they make decisions that have major negative outcomes. If a patient comes in complaining of headaches, the physician might order an MRI. But if the company refuses to pay for it, that person would have little recourse if he or she suffered a ruptured aneurysm.

Q. What kinds of skills or background do you bring to this office?

A. I think I know as much about the total health care system as anyone in the state. I've been involved in a multispecialty group, which forces you to understand how different specialties take care of people with several kinds of problems. I've been very involved with hospitals on their finance and budget committees for years. I've

been director of health planning for the state of New Jersey in the northern region of the state. I've also been on the board of the New Jersey Hospital Association for many years.

Q. Would you say that you bring an appreciation of the political process as well?

A. I try to. The reality is that many of the decisions that affect us are not made on a purely intellectual basis. Many of the things that affect medicine and health care are the result of political compromise. That's a foreign world for most doctors, either because they were never exposed to it, or they consider it a dirty business. Like it or not, that is the system, and if you don't understand it and are not willing to work with it, you have no chance of getting the best results.

Q. Do you think that young physicians coming out of medical school today are prepared for the changing realities of medicine?

A. I think they are prepared for the economic realities. First of all,

there's a much greater acceptance of two-income families than there was in my generation. Along with that, there is a greater sense of being a 9 to 5 work mentality. The notion of the physician being an employed solo practitioner will not exist outside of some rural town. Very few people and their families would tolerate the lifestyle that requires. Also, the breadth of knowledge required to care for patients is more than any individual today can possess. Let's say or not, doctors have to consolidate to get any kind of bargaining power in this managed care environment.

Q. Is New Jersey behind the curve in terms of managed care penetration?

A. Absolutely. We're seeing rapid consolidations in the managed care industry, which is exempt from federal antitrust law. Universal Healthcare controls 70 percent of the non-Medicare dollar in southern New Jersey. Can you imagine some automobile manufacturer controlling 70 percent of the market? Congress would be holding

arings. So the managed care companies have the best of all possible worlds. Like a utility, they can have whatever monopoly they want. Yet, unlike a utility, they can't make as much profit as they want. They need to educate the public to understand this better.

Q. You've said that MSNJ is one of the most influential state bodies in the country. Why do you think that is?

A. New Jersey is one of the most homogeneous states in the nation. We are an increasingly suburban state, with a very small rural population and our big cities are not really that big. On top of that, geographically New Jersey is a small state. Therefore, it's relatively easy from a logistical standpoint to get doctors together. When they do get together, they're often dealing with similar problems. In states like New York or California, it's much harder to get doctors together and they often are dealing with different kinds of problems.

Our leadership has done a number of wise things, such as starting and supporting the Medical Inter-

Insurance Exchange. MSNJ's executive director, Vincent Maressa also is an extremely effective administrator.

We also have a core of very involved members. What happened to other people is what happened to me. Twenty years ago somebody asked me if I would be a representative to the county medical society. When I got to the county medical society, there were many people who were very sharp, who knew things about which I was very ignorant. So people like me tend to stick around, and it tends to feed on itself. As a result, you have at least 50 to 60 people who are very involved, who give a lot of their time and energy.

Q. Organizationally, what challenges do you see facing MSNJ?

Carl Restivo, Jr, MD, MSNJ immediate past-president, and Dr. Sachs.



A. As the individual practitioner's economic situation weakens, and as he or she is forced to consolidate into larger organizations, there's a tendency to think that they can't afford or don't need membership in a professional society as much as before. People in a group practice might feel that they all do not have to belong to MSNJ, that they can get the same benefits if one or two physicians in the group become members.

Q. Or they may be more interested in joining a specialty organization?

A. That too, although I think that specialty organizations hit their peak maybe 10 or 15 years ago when medicine was in its true golden era. The intellectual aspects of medicine then were the driving force. Now, I think that specialists are realizing that on both the federal and state levels they have to make their medical societies work for them. Here, at MSNJ rather than through their specialty group, they can apply political leverage.

To increase cash flow, simply remove the tail.

Most New Jersey malpractice insurance policies require you to purchase a reporting endorsement — known as a tail — to protect against claims that may occur during retirement. B.C. Szerlip offers a unique policy from an A+ rated company that does not include an annual tail premium. In fact, if you maintain coverage with us until retirement, you'll *never* have to purchase a tail, and you'll still be protected.

That's just one example of the creative ways that B.C. Szerlip has discovered to help doctors with their long-range financial planning.

At B.C. Szerlip, we take a big-picture view of your practice, offering you comprehensive insurance and financial planning services. You can benefit from our nearly two decades of experience providing malpractice insurance for medical offices both large and small. In addition, our financial planners can offer strategic guidance for the overall health of your business affairs, so you can stay focused on the health of your patients.

We'd like to give you a taste of our full-service approach by sending you *The Managed Care Survival Kit for Physicians*. To receive your complimentary copy of this useful guide, please call us at 800-684-0876.

BCSZERLIP INSURANCE AGENCY INC.

99 WOOD AVENUE SOUTH, PO BOX 217
ISELIN, NJ 08830-0217
800-684-0876 • 732-205-9800
FAX: 732-205-9496
E-MAIL: bcszerlip@aol.com

*Professional Insurance Services
for Health Care Providers*

John Paul Dizzia, P.C. ATTORNEYS AT LAW

Legal Counseling and Representation to Medical Professionals in administrative, regulatory and disciplinary matters before the State Board of Medical Examiners, the Department of Insurance, the Division of Medical Assistance and Health Services, and in the law relating to professional rights, responsibilities, ethics and practice issues.

Member:

- National Health Lawyers Association
- Health and Hospital Law Section, New Jersey Bar Association
- New Jersey Association of Professional Mediators

108 North Union Ave.
P.O. Box 886
Cranford, N.J. 07016

Call: (908) 276-6111
FAX: (908) 276-5833
E-Mail: JPDLaw@WORLDNET.ATT.NE

The Medical Manager Practice Management Software

A fully integrated practice management solution

Over 16 years' experience in providing healthcare automation solutions

Provides an open system architecture and flexibility for specialized needs

Designed for small group practices to large Integrated Delivery Systems

Overwhelming national presence

Learn more about how Medical Manager Corporation and The Medical Manager system can meet your needs. Contact us at 800.677.7784, 201.808.0088, or www.medicalmanager.com.

Medical Manager

Corporation
RTI, Inc. and Medix

Empowering the Industry Through Partnerships

PROVIDING FOR NEW JERSEY PHYSICIANS PROTECTION

OLD STEPS HAVE BEEN TAKEN IN NEW JERSEY TO MAKE PHYSICIANS THE DECISION MAKERS

PHYSICIAN-PATIENT RELATIONS. RIGHT NOW, NEW JERSEY PHYSICIANS HAVE MORE POWER AND

PROTECTION THAN THEIR COLLEAGUES NATIONWIDE. IT'S TIME FOR PHYSICIANS TO MAXIMIZE SUCH POTENTIAL.

by Maria Falca Morgan

Last year, Governor Whitman signed new legislation that gave doctors new leverage in contracting with managed care plans and HMOs. On the national scene, President Clinton has proposed legislation that mirrors much of the New Jersey response. Presently, New Jersey physicians have more power and protection than their physician colleagues nationwide. The key to maximizing these opportunities lies in learning how to navigate the maze of state regulations.

A new program designed by the MIIX Healthcare Group (MHG), called Managed Care Protection (MCP) allows physicians to gain the most out of the recently enacted Patient Bill of Rights by seeking expert advice and legal counsel, if needed, at an affordable cost.

The purpose of MCP is to assist physicians as they initiate and continue relationships with HMOs. Legal advice is provided so problem areas that previously affected a physician's practice with HMOs—contract reviews, appeals, com-

Patient Bill of Rights

- HMOs must employ a medical director who is a New Jersey licensed physician. The medical director will oversee all provider contracts, direct all health care services, and manage ongoing quality improvement and utilization management programs.
- HMOs must meet minimum requirements for adequate provider networks, with reasonable access to specialists and minimum waiting times for emergencies, urgent care, and routine appointments and physicals.
- The decision to deny or limit coverage for patients must be made by physicians, who now can initiate the appeal process for patients denied care without the threat of retaliation or termination by HMOs.
- Gag clauses are prohibited in the contractual relationship between HMOs and physicians, enabling physicians to freely discuss all treatment and testing options.
- HMOs must establish a formal peer review process that requires the use of physicians within the same discipline and area of clinical practice.
- Patients cannot be refused enrollment because of pre-existing medical conditions, age, sex, or past utilization of services.
- Patients are entitled to receive from their physician a complete explanation of their medical condition and all recommended treatments, whether or not these are benefits covered by the patient's plan.



DHSS Commissioner Fishman advocated for HMO regulations.

plaints, and payment issues—can be avoided.

"We designed the MCP program as a natural extension of the consulting services offered by MIIX Healthcare Group to help physicians manage the business of medicine," says David L. Knowlton, MHG's president. "The services offered under this program can guide a physician wishing to advocate or file an appeal on a patient's behalf with a managed care plan. When a particular issue—such as an HMO or managed care contract review—requires legal advice, we may recommend that you speak with an attorney."

As needed, the law firm of Saiber, Schlesinger, Satz & Goldstein, LLC, provides legal services to participants in the MCP program. Directing the firm's health care practice is Robert J.

Fogg, Esq., who has served as director of Licensing and Certification for the New Jersey Department of Health and Senior Services where he was the principal author of the newly enacted HMO regulations. Fogg was instrumental in crafting the new appeals mechanism to benefit patients and physicians.

Participants in the MCP program pay an annual subscription fee, which covers advice from MHG and a set number of legal services. Some legal services outside the parameters of the program are available at reduced fees. Additionally, physicians receive timely legislative news and information that could impact their practices.

The MCP program's annual subscription fee covers:

- *MHG consultation.* On matters relating to rules and regulations affecting New Jersey physicians and surgeons, MCP recommendations may include seeking legal counsel.

- *Managed care contract reviews.* MCP offers legal reviews of five managed care contracts (within a 12-month period) that highlight areas likely to pose concerns to physicians. These reviews give advice on potential problems, such as utilization review denials, termination rights, and fraud and abuse concerns. Contract reviews exceeding five per year are available for \$75 per contract.

- *Stage 1 appeals.* Current HMO regulations provide a mechanism for three stages of appeals in cases of utilization management or denial of patient benefits. Appeals begin with stage 1, an informal process. After stage 1, appeals may progress to a formal internal process (stage 2), and end with a formal external appeals process conducted by an independent utilization review organization (stage 3), which has direct oversight by the Department of Health and Senior Services. The MCP program subscription fee provides legal advice—either a limited consultation or a written summary—for up to ten stage 1 appeals per year. Fee discounts for legal services are offered for stage 2 and stage 3 appeals.



David L. Knowlton, president,
MIIX Healthcare Group

- *Physician alerts.* A quarterly publication provides physicians with timely information about specific HMO developments, such as cautions and advice when negotiating contracts. Other issues addressed might include broad contractual concerns, as well as a managed care organization's history of denial of benefits, processing complaints, appeals, or terminating other providers.

- *Payment issues.* Participants in the MCP program receive fax alerts that keep them informed about general patterns or trends of prompt-pay issues.

- *Complaints and termination rights.* Under the new managed care regulations, physicians cannot be terminated solely as a result of complaints or appeals filed on behalf of their patients. The mechanisms for pursuing termination action by an HMO vary, and the responsibility for responding rests with the physician.

In addition to the services provided under the MCP program, physicians may need assistance to recognize and act upon other rights available to them by law. For these circumstances, MHG has negotiated special arrangements so that physicians may receive legal counsel, at a reduced fee, for advice when facing stage 2 and stage 3 appeals, managed care defense, and complaints against the HMO.

In case of complaints, physicians also have the right under the new rules to voice general complaints regarding broad practice issues within an HMO. The complaint system can vary with each HMO. For participants, the MCP program will provide initial consultation on specific systems as well as referrals to legal counsel.



HEALTH LAW PRACTICE

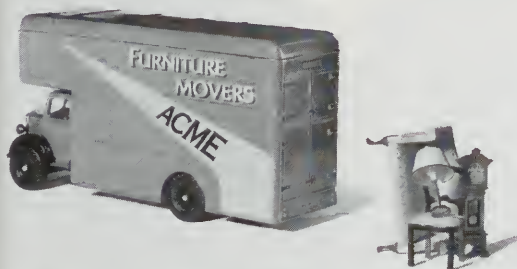
representing healthcare providers, including physicians, physician groups, other clinical professionals, academic medical centers, multihospital systems, independent acute care and specialty care hospitals, ambulatory care centers, and nursing and assisted living facilities

For more information or a copy of our
New Jersey Health Law Advisory,
please contact
Alma L. Saravia
51 Haddonfield Road
Cherry Hill, NJ 08002 • (609) 488-7300

DUANE, MORRIS & HECKSCHER LLP A PENNSYLVANIA LIMITED LIABILITY PARTNERSHIP

Cherry Hill and Newark, New Jersey
with additional offices in
Pennsylvania • New York • Washington, D.C.
Delaware • Florida

**Imagine If Every Time You Moved
You Lost 40% Of Your Furniture.**



**Moving Your 401(k) Funds Incorrectly Could Cost You.
Call For Your Free Information Kit Today.**

Moving funds from your former employer's retirement plan could cost you 40% or more of your savings in taxes and penalties.

T. Rowe Price can help. Call us for our free kit on managing your retirement plan distribution. It clearly explains the pros and cons of your options. Remember, your retirement savings have to last even longer than your furniture. So handle them with care.

1-800-541-1739

Invest With Confidence
T. Rowe Price

T. Rowe Price Investment Services, Inc., Distributor. IRA042333

Specializing in the Business of Health Care

Physician Practice Assessment/Contract Negotiations
Fee Schedule & Super Bill Analysis/New Practice Set-Up
Coding Issues/Risk Management

Call Evelyn Gross, CMM, CPC
(201) 261-4030

HUNTER HEALTHCARE SERVICES

Division of RD Hunter & Company LLP
Paramus, NJ New York City

EMERGENCY PHYSICIANS

Emergency Physician Associates, a Team Health affiliate, is seeking quality ED physicians for a variety of practice opportunities in NJ, PA, MD, NC and NY.

We offer physicians competitive compensation, flexible schedules, malpractice insurance, a variety of practice settings, and supportive Medical Directors.

Interested candidates may call

1-800-848-EPA-1.

YOU PRACTICE I'LL REORGANIZE YOUR EXISTING OFFICE



Is your staff working up to it's potential? Is your office operating efficiently? Are your codes current? If not, consider the turn-key method. Mary Ann Hamburger has triumphed as the most comprehensive and diverse single source for medical office set ups and reorganizations. She is an expert in every detail of office administration. Mary Ann will reorganize and reenergize your

present office. She can guide you in establishing the fee schedules appropriate to your specialty, geographic area and current market. She'll train your staff in scheduling properly to insure effective patient flow. An expert in CPT and ICD codes, Mary Ann Hamburger will update them yearly to insure proper reimbursement. For a whole new approach to medical office practice, call today.

MARY ANN HAMBURGER
A S S O C I A T E S

THE SPECIALIST'S SPECIALIST

74 HUDSON AVE. MAPLEWOOD, N.J. 07040
201-763-7394

You take care of your patients. We'll take care of the health of your practice. Our group of health care accounting specialists provides the medical community with the right type of analysis and counseling to be successful.

Since we're dedicated to increasing your profitability, never simply reporting it, we'll see

to it that your practice stays healthy for many years to come. To experience our unique approach, please call Ira S. Rosenbloom, Managing Director, at 973-882-1100.

PRACTICE GOOD FINANCIAL MEDICINE.



Mintz Rosenfeld & Company LLC

Profitability Consultants • Certified Public Accountants
60 Route 46 East, Fairfield, NJ 07004
Tel: 973-882-1100 Fax: 973-882-1560

OUR FOCUS IS YOUR SUCCESS.

LET'S TALK!

NEED A BUSINESS LOAN?
CALL US FOR...

EXPERT HELP
FABULOUS SERVICE
COMPETITIVE RATES
FAST APPROVALS AND CLOSINGS

Loans up to approx. \$1,500,000 under the U.S. Small Business Administration Guaranteed Loan Program.
Approvals in 24 hours, or less.

Preferred (PLP) lender in New Jersey, New York and Pennsylvania.



Call 1-800-SBA-2005
ask for the "SBA Specialist"

PRESTIGE STATE BANK



Equal Housing Lender Equal Opportunity Lender

Member FDIC

MAC

Equal



Excel Business Park

501 Prospect Street

Unit 96

Lakewood, NJ 08701

Phone: 732-886-0600

Fax: 732-886-0911

"The overall effect is total customer satisfaction."

- Medical/Dental Cabinetry
- Nurses Stations
- Reception Desks
- Nourishment Centers
- Medical/Dental Procedure Carts
- Computer Desks
- Monitor Cabinets
- Chart Racks
- Corian® Solid Surfacing
Certified Fabricator #C-5112
- Space Planning/Layout

THE FIELD OF RADIATION ONCOLOGY

BETWEEN 50 AND 60 PERCENT OF ALL PATIENTS WITH CANCER WILL REQUIRE RADIATION TREATMENTS AT SOME STAGE IN THE EVOLUTION OF THEIR DISEASE. NEW TECHNIQUES AND UPDATED METHODS IMPROVE SURVIVAL OUTCOMES AND QUALITY OF LIFE. RADIATION ONCOLOGY ZOOMS IN TO THE 21ST CENTURY WITH GREAT SUCCESS.

Ismail Kazem, MD; Michele Hazard

Radiation therapy is used as the sole treatment modality or in combination with surgery and/or chemotherapy. It is used for definitive treatment of some early cancer sites

with curative intent, as adjuvant to other treatment modalities to enhance the probability of cures, or to improve local disease control. It also is used in advanced disease for palliation of symptoms, such as relief of pain, relief of pressure on

critical organs, or to stop hemorrhage due to tumor ulceration.

Since its discovery in 1895, x-rays have been employed in the treatment of cancer. In the past century, radiation oncology reached a high



degree of sophistication. With precise technology, 3-D treatment planning, based on accurate imaging and a better understanding of tumor lethal dose and normal tissue tolerance, more cures, and fewer side effects, are attainable.

Computer and space technologies have impacted all aspects of medical practice and radiation oncology has benefited tremendously.

TREATMENT DELIVERY UNITS

High-energy linear accelerators, relatively compact in size and highly sophisticated in performance, now are available. Precision movement of the treatment table and the radiation beam can be automated and programmed. The energy levels of x-ray beams and/or electron beams can be selected. With the multileaf collimator, the shape of the treatment field can be designed to "conform" with the desired contour of the target volume (Table), the conformal radiation therapy. Thermoplastics and various immobilization molds and devices help in supporting the patient in position for accurate reproducibility during daily treatment sessions.

TUMOR LOCALIZATION

The introduction of CT-based tumor localization and treatment simulation eliminated the guesswork from radiation treatment planning. The radiation oncology CT-simulator provides CT image slices of the body, which can be reconstructed digitally as a reference radiograph. The image slices provide an accurate outline of the body contour, definition of anatomic boundaries, electronic delineation of the selected target volume, and an outline of critical organs that need to be protected or spared a high-radiation dose. Three-D rendition of these CT images is a prerequisite for 3-D

treatment planning and conformal radiation therapy.

TREATMENT PLANNING

Several computer based 3-D treatment planning systems are available commercially. These systems provide radiation dose calculation and distribution in the selected target volume. Thus, the radiation oncologist is able to determine, at a glance, regions of under or over dosage within the total target volume, not only in the central section of the plan. Dose distribution optimization can be attained by varying the dose intensity contributed by each radiation beam used. In its most sophisticated version, dose-intensity-modulation programs can provide inverse planning. The dosimetrist and/or the radiation oncologist would plot the desired ideal volume dose distribution, and the system program would determine the intensity and direction of the radiation beams that can achieve the desired result.

STEREOTACTIC RADIOSURGERY

A specific application of modern technology is to treat a small target volume with a very high-radiation dose. Initially, the technique was introduced to treat arteriovenous malformations and small brain tumors close to sensitive parts of the brain where surgery would be too

**A SPECIFIC APPLICATION
OF MODERN TECHNOLOGY
IS TO TREAT A
SMALL TARGET VOLUME
WITH A VERY HIGH
RADIATION DOSE.**

Table. Target volume definitions

- Gross Tumor Volume (GTV), gross palpable or visible extent and location of tumor.
- Clinical Target Volume (CTV), contains GTV as well as sub-clinical microscopic extent.
- Planning Target Volume (PTV), includes margins added to CTV to compensate for patient or organ movement and set-up inaccuracies.
- Treated Volume (TV), volume enclosed in a selected dose distribution (isodose lines) for the purpose of treatment.
- Irradiated Volume (IV), tissue volume that receives a dose considered significant to normal tissues.

risky, thus the name, radiosurgery. In this technique, small focused radiation beams (pencil-beams) rotate around the center of the target volume delivering a high-intensity radiation dose given in one fraction, but sometimes divided in few fractions to avoid intense tissue reaction. The success of this time-consuming technique depends on the precision of the planning, treatment delivery, and the accuracy of defining the target volume.

BRACHYTHERAPY

Brachytherapy is an old technique revived with modern technology utilizing small radiation sources that are implanted directly into the target volume (interstitial implants), or

brought into a body cavity in close proximity to the tumor bearing volume (intracavitary brachytherapy). Brachytherapy utilizes radiation sources of low activity that deliver the radiation dose over a few days, i.e. low-dose rate brachytherapy, or brachytherapy uses a high-activity radiation source that delivers the desired dose in minutes, i.e. high-dose rate brachytherapy. High-dose rate brachytherapy is given as outpatient therapy by a remotely controlled after-loading system in a suitably shielded room. It is used successfully for intracavitary treatment of uterine cancer and endobronchial treatment of bronchus carcinoma, and for the endoesophageal treatment of esophageal cancer. Low-dose rate brachytherapy is used for the interstitial seed implants of early prostate cancer, for suitable head and neck cancers, and for soft tissue sarcomas.

INFORMATION MANAGEMENT

The degree of sophistication of modern radiation oncology technology needs a reliable electronic management system to provide several essential organizational and quality control tasks. This guarantees the efficient running of the radiation oncology service, provides documentation of all activities, and ensures the safety and accuracy of treatments. The tasks include patient scheduling, electronic charting of clinical and treatment information, treatment planning and prescription, treatment delivery and verification, billing, and treatment outcome reporting.

RADIOBIOLOGICAL ADVANCES

Early radiation oncology was based on intuition and trial and error. Modern radiation oncology applies scientific knowledge ob-



Ismail Kazem, MD

tained from clinical and experimental research. Although the principal premise remains the same, i.e. achieving maximum damage to malignant tissues with the minimum of irreversible injury to normal tissues, advances in cell biology and molecular biology research have offered reliable predictability. Thus, different radiation dose fractionation schemes are utilized to counteract cell proliferation of cancerous tissues while allowing for normal tissue recovery. Chemical compounds called sensitizers are used to improve the "therapeutic ratio" by enhancing the radiation effect on cancer cells. Certain chemotherapeutic compounds help synchronize cancer cell division rendering them more susceptible to radiation damage. As molecular biology research unravels the genetic mysteries of the cancer cell, better understanding of the mechanisms that lead to programmed cell death or apoptosis will refine radiation therapy efforts.

CLINICAL ADVANCES

The recognition of the potentials and limitations of different treatment modalities in the management of patients with cancer has led to a multidisciplinary team approach. The cancer treatment team com-

bines surgical oncologists, radiation oncologists, and medical oncologists for the caring of patients with cancer. This ensures the choice of the most optimum treatment options. The most effective management is a combination of surgery, radiation, and chemotherapy. Cancer clinical trials have served to guide the clinician to the most acceptable standard of care based on the outcomes of different treatment approaches. Survival and quality of life issues are evaluated. This new trend in an organ sparing approach to treatment has proved to be effective in survival outcome and in improving the quality of life. Examples of this approach are: breast preservation in the treatment of early cancer of the breast by lumpectomy and radiation therapy; limb-sparing surgery combined with radiation for soft tissue sarcomas; organ preservation of advanced laryngeal carcinoma by combining chemotherapy and radiation; sphincter preservation of locally advanced rectal carcinoma by preoperative chemoradiation therapy followed by surgical resection and anastomosis; and curative treatment of squamous cell carcinoma of the anal canal by combined chemoradiation therapy.

Modern radiation oncology succeeds in improving the local control with reduction in the side effects. This translates into improved survival and better quality of life. ■

Dr. Kazem is director and Ms. Hazard is manager/team leader, Department of Radiation Oncology, Penn State Geisinger Health System, Danville, Pennsylvania. Kazem is a member of the MSNJ Council on Communications and of the Review Board for New Jersey Medicine.

HEALTH CARE CAN BE A MOVING TARGET!



WHEN YOU CAN'T AFFORD TO MISS . . .

**HANNOCH WEISMAN HAS A RECORD OF HITTING
THE MARK WHEN ADVISING PHYSICIANS ON:**

- ✓ Practice formation, management and operations
- ✓ Review and negotiation of managed care contracts
- ✓ Corporate transactions including mergers and acquisitions and joint ventures
- ✓ Licensing, peer review and disciplinary matters
- ✓ Professional liability and risk management
- ✓ Governmental and payor inquiries and investigations
- ✓ Medical staff relations and credentialing
- ✓ Employee relations and benefits

For assistance or information contact
Lisa D. Taylor, Esq.
James J. Shrager, Esq.


HANNOCH WEISMAN

A Professional Corporation, Counsellors at Law
4 Becker Farm Road, Roseland NJ 07068
973-535-5300

3-D COMPUTER GRAPHICS FOR MEDICINE

CT AND MRI PRODUCE MORE DATA THAN CAN BE VISUALIZED BY CONVENTIONAL DISPLAYS. SO NOW, PHYSICIANS RELY ON 3-DIMENSIONAL COMPUTER GRAPHICS TO OBTAIN A FIRM DIAGNOSIS OR TO PREPARE FOR SURGERY.

Three-dimensional computer image of the heart.

By Eric J. Lerner

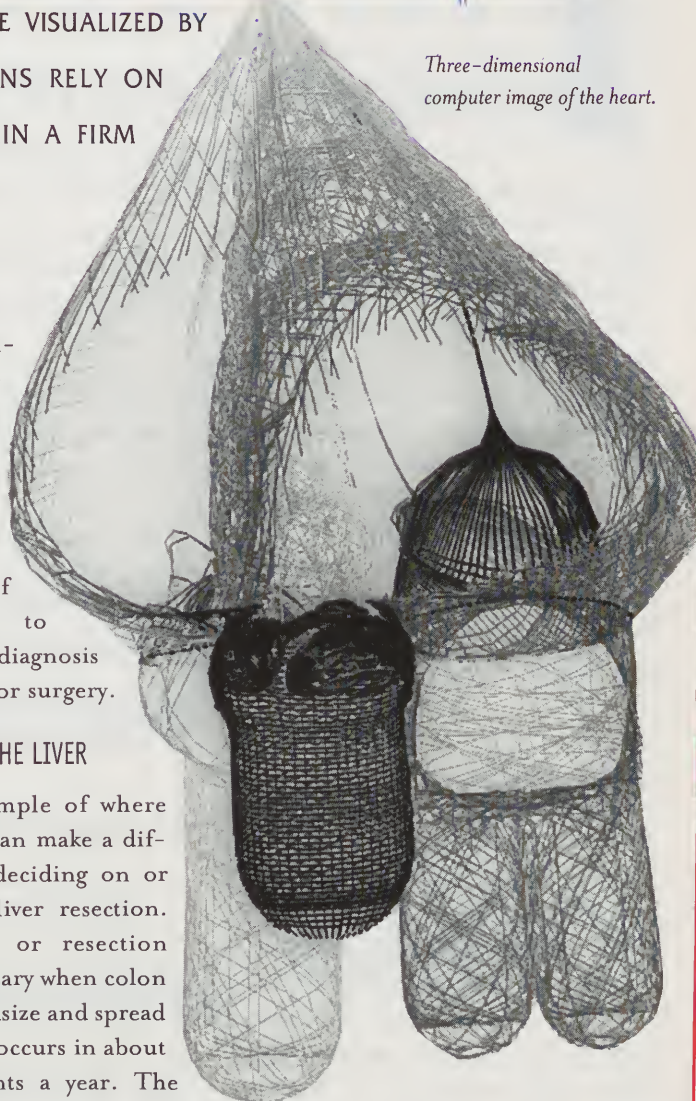
The remarkable three-dimensional (3-D) special effects churned out of the largest super-computers have become a staple of movies. Far less known is that similar 3-D computer graphic technology is beginning to serve the needs of physicians and surgeons.

High-performance diagnostics such as CT scans and MRI now are producing far more data than can be easily visualized with conventional, 2-dimensional displays, analogous to the traditional x-ray film. To get full use out of such tools, new methods of 3-D display are being developed. This is critical, especially when dealing with flexible organs such as the liver or the heart, where diagnosis requires an understanding of how the organ moves in three dimensions and over time. Potentially, new graphic

display methods, by maximizing the usefulness of diagnostic data, could rapidly reduce the number of tests needed to obtain a firm diagnosis or to prepare for surgery.

NAVIGATING IN THE LIVER

A good example of where 3-D graphics can make a difference is in deciding on or planning for liver resection. Liver surgery or resection becomes necessary when colon cancers metastasize and spread to the liver, as occurs in about 80,000 patients a year. The



only effective treatment of such cancers is surgical removal, and even then there is only a 30 percent, five-year survival rate. Without surgery, death is almost inevitable within a year. Unfortunately, most patients cannot be operated on successfully, because the tumors are too close to major veins and arteries. Currently, nearly one-half of the patients that are surgically explored for resection are not able to be resected.

It is of great importance to locate tumors and vascular structures accurately in three dimensions with noninvasive means, both to decide which patients can be resected and to plan the operation. This especially is true with the growing use of cyroablation, the destruction of tumors by freezing, which allows more selective destruction of deep tumors, but offers the surgeon little visual access to the process. (The low temperature probe is inserted deep within the liver, without cutting away the overlying healthy tissue.)

Fortunately, current CT scanning techniques can provide detailed data on the 3-D placement of tumors in the liver. The best technique is helical or spiral CT scanning, where the patient is moved throughout the scanner at constant velocity while the scanning beam rotates, providing a scan in only 30 seconds. This reduces errors caused by liver motion during breathing.

To be useful, the image must be presented in a clear 3-D manner. The first step is to have the computer segment the image into different regions that can be color coded for tumors, healthy tissue, and blood vessels. Generally, segmentation starts by classifying the intensity of a given volume element or voxel.

Then regions are built up of adjacent voxels of a given intensity. Depending on the shape of the region, an overall classification can be determined and a color code assigned. Thus, low intensity compact areas can be labeled as healthy tissue, intermediate regions with elongated branching shapes as blood vessels, and compact regions of high intensity as tumors.

To display the 3-D information on a flat screen, liver scans often are represented as rotating, so the relation of tumor and vessels is seen from continuously changing angles. The drawback with this is that one angle may be ideal for detailed study, but if the physician stops the rotation, depth cues are partially lost. Recent development is aimed at producing stereoscopic images that can be viewed through lightweight goggles, allowing static 3-D viewing.

THE HEART IN 3-D ANIMATION

Although the liver is viewed in 3-D, the heart must be viewed in four dimensions, including time. With heart disease the leading cause of death in the United States, some 400,000 bypass surgeries and 400,000 angioplasties are performed annually—nearly one-third of the population can expect to undergo such operations in their lifetimes. To determine the necessity of such major surgery often requires a battery of tests, which can

be expensive and time-consuming. Potentially, MRI can replace all of these tests with a single test that can present to the physician a detailed 3-D animation of the heart in action, enabling definite diagnosis of arterial blockage.

MRI scans of the heart can be performed sufficiently quickly so as to show a series of snapshots of the heart's contractions. Typically such snapshots are displayed as a cine-loop, a repetitive movie film. But until recently, small scale details of the heart contraction, needed to detect blockage, were not visible in such loops. The solution was to magnetically paint a stripped pattern onto the heart, revealing even small changes in heart motion. This is done, noninvasively, by changing the direction of nuclear spin in alternate stripes across the heart.

The result of this technique is a display with a moving picture of the striped heart, with regions that lag behind the contraction displayed as kinks or bends in the stripes. What is even more useful is that from the bending of the stripes, the computer can calculate the amount of strain, the actual amount of change in the shape of the heart wall, at each point and at each moment. This information then is displayed in color-coded animation. The area of highest or lowest strain, where a part of the heart wall is lagging behind the rest can easily stand out. The ability of the heart to contract is measured and the degree of blockage and its location can be determined.

Such advanced MRI imaging techniques are just moving from laboratory to the hospital. With increasing computer speed, 3-D graphics with 3-D animation may make the process of assessing coronary arteries a one-stop visit. ■

THE FIRST STEP IS TO HAVE
THE COMPUTER SEGMENT
THE IMAGE INTO
DIFFERENT REGIONS THAT
CAN BE COLOR CODED.

Only MIIX offers



the Toolkit that fits in your briefcase.

Provided by MIIX Financial Services

The MIIX Toolkit, designed specifically for physicians, explains how you can access:

- **MIIX Buying Service** — offering discounts up to 70% on quality medical and office supplies and equipment.
- **Equipment Leasing** — equipment lease financing and lines of credit at competitive rates.
- **Receivables Management** — providing collection of medical accounts receivable.

To find out more about this powerful resource,
call MIIX Financial Services at

1-800-227-MIIX.

Endorsed by the

Medical Society of New Jersey

MSNJ

MEDICAL INTER-INSURANCE EXCHANGE

POWERFUL PARTNERSHIPS



A F N D A

E V E N T

D A T E

L O C A T I O N

J u n e

Oncology Society Annual Meeting	June 10, 1998	Hyatt Regency, New Brunswick, AMNJ, 609.275.1911
Advanced Hospice Nursing Seminar	June 11, 1998	NJ Hospital and Palliative Care Organization, 908.233.0060
Chronic Pain Management and Issues Related to Iatrogenic Addiction	June 11, 1998	Shore Memorial Hospital, Somers Point, AMNJ, 609.275-1911
AMA Annual Meeting	June 14-18, 1998	AMA, Chicago, IL, 312.464.5000
A Day of Learning	June 19, 1998	New Jersey Institute of Technology, Newark, AMNJ, 609.275-1911
Aspects of HIV/AIDS	June 23, 1998	South Jersey Hospital, Elmer, AMNJ, 609.275.1911
Topics of Public Health	June 24, 1998	John Fitch Plaza, Trenton, AMNJ, 609.275.1911
Statewide Conference on Adolescent HIV/AIDS	June 24, 1998	Sheraton, Woodbridge, 973.972.6482
Lyme Disease	June 24, 1998	St. Mary's Hospital, Passaic, AMNJ, 609.275.1911
Physician Public Affairs Conference	June 25, 1998	MSNJ Headquarters, 609.896.1766
Hemodynamic Monitoring, Pharmacological Optimization, and Point of Care Laboratory Testing in the ICU	June 26, 1998	Ocean Place Hilton, Long Branch, AMNJ, 609.275.1911
12 th World AIDS Conference	June 28, 1998	Geneva, Switzerland

J u l y

Medicine in the Face of the New Millennium	July 2-5, 1998	Westin Rio Mar Resort, 800.888.6235
--	----------------	-------------------------------------

A u g u s t

Intensive Review of Internal Medicine	August 2-7, 1998	College of Physicians and Surgeons, New York, 212.781.5900
---------------------------------------	------------------	--

S e p t e m b e r

Renal Biopsy in Medical Diseases of the Kidneys	September 16-19, 1998	College of Physicians and Surgeons, New York, 212.781.5990
Psychiatry Update 1998	September 26, 1998	College of Physicians and Surgeons, New York, 212.781.5990

O c t o b e r

Controversies in Women's Health	October 3, 1998	College of Physicians and Surgeons, New York, 212.781.5990
Sports Medicine	October 7, 1998	MSNJ, Lawrenceville, 609.896.1766
Cancer Survivorship	October 8-10, 1998	Caesars Hotel, Atlantic City, 212.366-6565
Lyme Disease	October 17, 1998	College of Physicians and Surgeons, New York, 212.781.5990
HealthPack '98	October 20-21, 1998	Hyatt Regency, Tampa, Florida, 717.291.5609
Dermatology for the Primary Care Physicians	October 31, 1998	College of Physicians and Surgeons, New York, 212.781.5990

N o v e m b e r

MRI Symposium	November 6-8, 1998	Radiological Society of New Jersey, Somerset Marriott,
Psychiatry in Primary Care	November 14, 1998	College of Physicians and Surgeons, New York, 212.781.5990 AMNJ, 609.275.1911



**ALLEGHENY
UNIVERSITY OF
THE HEALTH SCIENCES
MCP♦Hahnemann School of Medicine
ALLEGHENY UNIVERSITY HOSPITALS**

Office of Continuing Medical Education

presents

**OFFICE MANAGEMENT CONFERENCES
FOR THE
PRIMARY CARE PHYSICIAN**

Mark your calendar!

SEPTEMBER 1998

Cardiology Update Series	September 9	AUH-MCP, Kaiser Auditorium.	3:00-5:00 pm
19th Annual Office Management of Heart Disease-A Primary Care Prospective	Sunday September 27	Ashbourne Country Club Cheltenham, PA	8:00-1:00 pm
19th Annual Arrhythmia Symposium	September 28	Adam's Mark Hotel	8:00-5:30 pm

OCTOBER 1998

Cardiovascular Disease Update	October 2-3	Chateau Lake Louise Alberta, Canada	8:00-12:30 pm
Cardiology Update Series	October 7	AUH-MCP, Kaiser Auditorium.	3:00-5:00 pm
Office Management of Orthopedics Series	October 10	AUH-Hahnemann, Alumni Hall	8:00-11:00 am
Gastroenterology Update, 1998	October 17-18	Mountain Laurel Hotel/Golf Club White Haven, PA	8:00-12:30 pm

For information or to request a brochure - call 215-762-8263

Allegheny University of the Health Sciences, MCP♦Hahnemann School of Medicine is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor Continuing Medical Education for physicians.

Allegheny University of the Health Sciences, MCP♦Hahnemann School of Medicine designates these educational activities for Category 1 credit on an hour-for-hour basis towards the AMA Physician's Recognition Award. Each physician should claim only the hours of credit that he/she actually spent in the educational activity.

These programs are eligible for hour-for-hour credit in Category 2A of the American Osteopathic Association.

INTERNATIONAL COLLEGE OF

ACUPUNCTURE & ELECTRO-THERAPEUTICS

(Permanently Chartered by the University of the State of New York,
State Education Department)

1998 Seminars & Workshops & 14th Int. Symposium

ACUPUNCTURE & ELECTRO-THERAPEUTICS in Clinical Practice

25 credit hours can be earned by attending
one three-day weekend (Friday-Sunday) session 9 am-7 pm

June 19-21, 1998	Holiday Inn, Manhattan
Sept. 18-20, 1998	440 W. 57th St, NYC between 9 & 10 Ave
Nov. 20-22, 1998	Hotel 212-581-8100 during meetings
Dec. 11-13, 1998	

14th Annual International Symposium, Oct. 22-25, 1998

the School of Int'l Affairs, Columbia University

In addition to holding 7-8 seminars & workshops per year, the International College of Acupuncture & Electro-Therapeutics organizes an Annual International Symposium every October at the School of International Affairs, Columbia University, NYC and publishes *Acupuncture & Electro-Therapeutics Research*, *The International Journal* quarterly, through Cognizant Communications and is listed by 15 major international indexing periodicals (*Index Medicus*, *Current Content*, *Excerpta Medica*, etc.), is recognized as a major leading journal in the field. The most prestigious and internationally recognized, "Fellow of the International College" (F.I.C.A.E.) will be awarded to members of the College who present a minimum of 2 original research papers during the annual International Symposium and publish them in the official journal, or who have made significant contributions in the field.

These seminars & workshops train physicians and dentists in the latest theories and techniques of manual & electro-acupuncture, TENS & simple non-invasive diagnostic methods (including cardiovascular, neuro-muscular, central nervous systems & Bi-Digital O-Ring Test). For information, contact Dr. Y. Omura, MD, ScD, FICAE, 800 Riverside Drive (8-I), NY, NY 10032; 212-781-6262, Fax 212-923-2279 or Dr. Richard Simon, PhD, 212-662-7022 or Ms. Sandra Beckman, MA, 212-679-8986. All ICAE meetings are accredited by the New York State Boards for Medicine and Dentistry toward the 300 accredited hour requirement for the Acupuncture Certificate in New York State. Also eligible for AMA/CME Category I credit. MSSNY designates this CME activity for AMA/CME Category I credits toward Physician Recognition Award.



FOCUS FINANCIAL GROUP

1220 Bay Avenue
Toms River, NJ 08753

DOCTOR DO YOU NEED A 2ND OPINION?

Many physicians are finding their income stream eroded by changes in the economics of the health care delivery system. Therefore, it is important that every dollar invested has maximum growth with minimum risk.

In today's financial market the right financial advice can make the difference. If you don't have one or not satisfied with the one you have, then seek a **SECOND** opinion from the **SPECIALIST**:

**Call Joseph T. Hayes, M.D., M.P.H.
M.S.M., F.A.C.O.E.M.**

The Focus Financial Group is the only Registered Investment Advisor New Jersey with Certified Financial Planners and a Licensed Board certified physician who is also fully licensed in securities and insurance.

**for free consultation or brochure:
1-800-774-1734**

registered representative of Cadaret Grant
& Co., Mt. Arlington, N.J., member nasd/sip

How the Pros deliver the difference

You have a new choice in medical liability insurance. Meet the Pros.

What sets one insurance company apart from another? Now that ProSelect has come to your state, you can find out.

ProSelect is a member of the ProMutual companies, which have been insuring healthcare professionals for over 20 years. We are one of the largest professional liability companies in the Northeast, and you'll see the benefits of our knowledge and our experience in many ways.

Here's what the Pros can offer you:

- Comprehensive Risk Management Services. Attend seminars and receive computerized office appraisals to help you improve specific areas of your practice. Based on volumes of claims data and experience, we respond to real liabilities, and offer real programs to minimize your risk.
- Representative of the Day. You can always call and talk to a claim or risk management expert about any questions you have, about your policy, your risks, or your practice.
- The best defense attorneys in the Northeast, teamed with our responsive Claim Service Representatives who keep you informed at every stage of your claim.
- An aggressive defense policy — and a trial success rate above the national average.
- A wide range of liability policies. We've always focused exclusively on healthcare providers, and we use our experience to develop products that protect our policyholders from the range of risks they face.

There is a difference in professional liability insurance. To find out what the Pros can do for you, call the ProMutual companies today at 1-800-225-6168, extension 247.

TALK TO THE PROS.



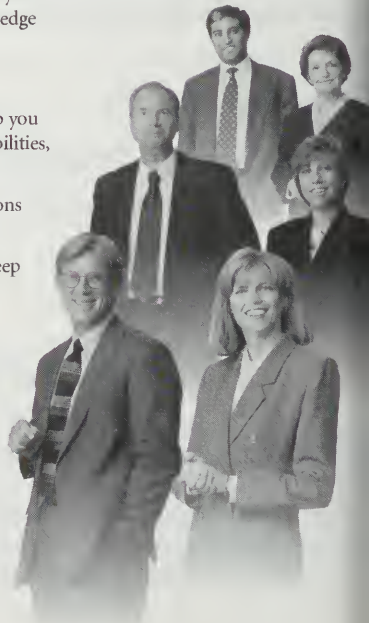
A member of the ProMutual Group of companies,
offering healthcare liability protection in CT, MA,
RI, VT, NJ, ME,* and NY.*
* Pending approval of the Division of Insurance in
these states.



A member of the ProMutual Group of
companies, offering healthcare liability
protection in Massachusetts.



Rated "A-"
for overall
Liability
Coverage by
A.M. Best.



THE MEDICAL SOCIETY OF NEW JERSEY CLASSIFIED ADVERTISEMENT INSERTION REQUEST

RATES

(Placement in New Jersey *MEDICINE* OR on WEB Site)

New Jersey *MEDICINE*

<http://www.msnj.org>
WEB Site

Per Month—Non-Members

Minimum 45 words \$ 45.00

plus each word
over 45 words \$ 1.00

Per Month—Members

Minimum 45 words \$ 30.00

plus each word
over 45 words \$ 1.00

Per Month—

Minimum 45 words \$ 45.00

plus each word
over 45 words \$ 1.00

(Placement in New Jersey *MEDICINE* AND on WEB Site)

New Jersey *MEDICINE*

<http://www.msnj.org>
WEB Site

Per Month—Non-Members

Minimum 45 words \$ 45.00 \$ 36.00

plus each word
over 45 words \$ 1.00 \$.80

Per Month—Members

Minimum 45 words \$ 30.00 \$ 36.00

plus each word
over 45 words \$ 1.00 \$.80

PREPARE YOUR COPY ON A SEPARATE PAGE AND ATTACH TO THIS ORDER FORM

INSERTION AUTHORIZATION

Name _____ MSNJ Member? Yes _____ No _____

Company _____ Telephone Number _____

Address _____ Fax Number _____

City _____ State _____ ZIP _____

New Jersey *MEDICINE* Issues _____

Web # of 30 Day Insertions _____

New Jersey *MEDICINE*

Non-Member

Minimum 45 Words \$ 45.00

+ Each Add'l Word @\$1.00 \$

Per Issue \$

X Number of Issues

AMOUNT DUE \$

New Jersey *MEDICINE*

Member

Minimum 45 Words \$ 30.00

+ Each Add'l Word @\$1.00 \$

Per Issue \$

X Number of Issues

AMOUNT DUE \$

MSNJ WEB SITE

Non-Member or Member

Minimum 45 Words \$ 45.00

+ Each Add'l Word @\$1.00 \$

Per Month \$

X Number of Months

AMOUNT DUE \$

MSNJ WEB SITE WITH

NEW JERSEY *Medicine* Placement

Non-Member or Member

Minimum 45 Words \$ 36.00

+ Each Add'l Word @\$.80 \$

Per Month \$

X Number of Months

AMOUNT DUE \$

TOTAL DUE \$ _____ ALL CLASSIFIED ADS MUST BE PRE-PAID

Please make check payable to "Medical Society of New Jersey"

Mail to: Classified Ad Department
370 Morris Avenue
Trenton, NJ 08611

Tel: 609-393-7196
Fax: 609-393-3759

CLASSIFIED ADS

100 OPENINGS PHYSICIANS (MULTIPLE SPECIALTY)

BOARD CERTIFIED M.D.

Nationally recognized paramedical company is seeking Board Certified M.D.'s: Family Practice, Internal Medicine for mobile health examinations and venipuncture for insurance clients. Flexible schedule. Please respond by calling 800-322-8094; Department 3.

110 OPENINGS PHYSICIANS (ALPHABETICAL BY SPECIALTY)

BC/BE ANESTHESIOLOGIST

Pain Management Only—New Jersey (Central/Northern—½ hr. from N.Y.C.). Outstanding private practice opportunity for BC/BE Anesthesiologist. Pain Fellowship is a plus. F/T or P/T. Most established pain group in the state. No night calls or wknds. Avail. 07/01/98. Fax short CV & cover letter to 732-651-0375.

DERMATOLOGY PRACTICE OPEN OPPORTUNITY

Thriving well-established practice on Jersey Shore seeking energetic individual to assume practice. Can also accommodate P/T work, 1-2 days/wk; terms negotiable. Confidential Box #137, New Jersey MEDICINE, 370 Morris Avenue, Trenton, NJ 08611.

BC/BE PEDIATRICIAN

To join Pediatric Group Practice. Competitive Salary. Early Partnership. Please send CV to Cape Pediatric Associates, P.A., 301 Dennisville Rd., Cape May Court House, NJ 08210.

INTERNAL MEDICINE

Internal Medicine. Family Practice. Mercer County/Princeton Area. Seeking BC/BE Internist/Family Practitioner to join busy medical practice in the Mercer County, Princeton Area. Competitive Salary, full Benefits Package. Recent Residency Graduates welcomed. Contact Dr. Joseph De Blasio. 609-586-6006.

PEDIATRIC PRACTICE UNION COUNTY

Excellent opportunity for a pediatrician to join an established practice. Competitive salary. Flexible schedule. Fax CV to 908-889-8965.

130 OPPORTUNITY WANTED

BC FAMILY PRACTITIONER

BC Family Practitioner—Seeks PT/FT employment. Call 973-994-1617.

BOARD CERTIFIED INTERNIST

Recent Graduate seeks practice opportunities in Morris/Essex/Union/Somerset/Middlesex County areas of N.J. Valid N.J. license. Call 201-342-3357.

RADIOLOGIST

Radiologist searching for a part time job. Lot of experience in General Radiology, Ultrasound & Mammography. Flexible hours. Nutley Postal Center #105, 460 Franklin Avenue, Nutley, NJ 07110.

200 PRACTICE FOR SALE

ENT PRACTICE

Gen ENT practice, solo in own building—established 28 yrs—South Jersey Shore area—15 min to Atl. City, 1 hr to Philadelphia. Enjoy the Shore, fishing, etc. Call 609-823-4273.

CLIFFWOOD

Close to three hospitals. One reception room. Three examining rooms. One consultation room. One billing room. One file room. One convenience room. One large bathroom. Utility room. Ramp access to wheel chair. Private entrance in rear. Parking lot. Completely fenced. One acre property. 732-566-0880 office Hrs. 9:00 am-5:00 pm.

FAMILY PRACTICE

Twenty year old, well established, exclusively Spanish population, primary care in a busy city area, for sale. Great opportunity for dedicated MD committed to quality care. Major HMO affiliated. Please call 973-484-5887 between hours of 11 am to 3 pm.

WEST ESSEX AREA OB-GYN

Practice or Space in Professional Building. Ready for interested party to continue as OB-GYN or other type medical service. Suitable for solo or group. Phone 973-533-9200 Ext. 107. Fax 973-535-8035.

300 OFFICE RENTALS AND LEASES

EDISON

Office Space—Edison Medi-Plex Building opposite J.F.K. Hosp. Fully equipped, turn-key. Rent day, full day, night. 732-494-6300.

HILLSBORO

Hillsboro Medical Office—1,500 sq. ft. \$1,000/mo. Busy location. Active practices in building. Ideal for new or 2nd practice. Call Dr. Wolinsky 212-476-7789 days or 215-860-8491 eves.

MILLBURN

Medical Arts Building. Millburn Avenue. equipped, turn key. Rent day, 1/2 day, or Call 973-376-8670.

MOORESTOWN, NJ

Medical Center. Excellent primary network—Family Practice/Pediatrics/OB-GYN. Need medical and surgical specialties. See offices available. Excellent Local 609-235-2651.

SOMERSET

Office Rentals. Route 27, Somerset. furnished reduced office space in professional building with 2 exam rooms, 2 consultation rooms, business office, etc. Available for time or full-time use. Call 732-246-4000.

325 MEDICAL BUILDING FOR SALE OR LEASE

NORWOOD (BERGEN COUNTY)

Superb, zoned, professional location in rapidly growing, N.E. Bergen County (Norwood). Detailed blueprints for new 2,200 sq. ft. Medical Dental Building included. Small, existing, ready home on site now. Priced to Sell! Call Dr. William Arnone @ 201-768-5697.

TEANECK (BERGEN COUNTY)

For Sale. Office Condo in Professional Building. 1,100 Sq Ft, 7 Rooms with 4 Exam Rooms. Lower Floor. Ideal Central Location on Corporate Lane. Available Immediately. Asking \$140,000. Call 201-385-3008.

420 FINANCIAL SERVICES

ALTERNATIVE FINANCING/MEDIATION

Where do you go when banks say "NO"? Our company has access to an extensive network of Alternative lenders willing to go where traditional banks won't. Business Debts that have overdue can cause real problems. We reduce debts by skillful negotiation. 732-416-0100

500 MEDICAL EQUIPMENT FOR SALE

BENNETT X-RAY

Available Bennett X-ray equipment. Ideal for chest and spine. Bargain. Call 215-945-2111. Quick Sell.

510 EQUIPMENT WANTED

USED DEXA MACHINE

Wanted: A used DEXA (Bone Density Machine) preferably a Hologic. Cash or installment. Please call 24 hours, Page 421-9795 or Dr. 609-586-1100 or Eves 609-924-4704 for doctor.



OF NORTH JERSEY & NEW YORK

is now

ImageFIRST™

MEDICAL WEAR

Lab Coats ■ Dentists Jackets
Patients Gowns ■ Towels ■ Sheets
Pillow Cases ■ And More!

*Changing and improving our
service for you!*

For information call:
1-800-368-3676

EMERGENCY PHYSICIANS

Emergency Physician Associates, a Team Health affiliate, is seeking quality ED physicians for a variety of practice opportunities in NJ, PA, MD, NC and NY.

We offer physicians competitive compensation, flexible schedules, malpractice insurance, a variety of practice settings, and supportive Medical Directors.

Interested candidates may call

1-800-848-EPA-1.

Hospitalists

A 355 bed community hospital in central New Jersey is seeking BC/BE Internal Medicine/Family Practice physicians for exciting new positions as "Hospitalists". Responsibilities include clinical inpatient care, resident teaching and limited clinical outpatient care. Excellent suburban location near NYC. Competitive salary and benefits.

For more information call: (908) 685-2487
or fax CV to: (908) 704-0083

You Live here.

But,

Your parents live there.

FLORIDA

We're there for your
parents when you can't be.



SERVICES PROVIDED BY LICENSED
SOCIAL WORKERS &
CERTIFIED CASE MANAGERS

- Short / Long Term Care Plans
- Geriatric Care Management
- Assessment of Needs
- Community Service Referrals
- Counseling
- Placement Services
- Medical Coordination
- Family Issues
- Crisis Intervention



LIFE CARE CONSULTANTS

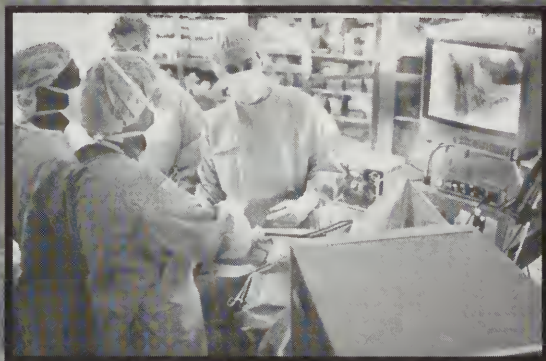
SERVING

MIAMI BEACH • FT. LAUDERDALE • PALM BEACH

1-800-569-9615

Photo Finish

In celebration of its centennial this month, we look at South Jersey Hospital-Bridgeton, an affiliate of South Jersey Health System, from the operating room in the early 1900s to modern surgical procedures in the 1990s (inset).



We welcome contributions to Photo Finish (color or black-and-white). Please include a 50-word description of the photograph. Send to Editor, New Jersey Medicine, Two Princess Road, Lawrenceville NJ 08648. Photographs will be returned.

NEW JERSEY MEDICINE

HEALTH CARE IN THE GARDEN STATE

JULY 1998



glove Story

*Latex meets
provider, faces
unhappy hands*

plus

Tourette SYNDROME

*Struggling to
understand it*

Walter Hughson Hasbrouck M.D.
10 Crestmont Rd
Montclair, NJ 07042

Y - O - U - R

PRACTICE

MADE MORE

PERFECT

WITH OVERHEAD EXPENSE INSURANCE FROM BLANKSTEEN

If you get sick, we'd like to help keep your practice well with overhead expense coverage that can reimburse office salaries, rent, insurance premiums, and utilities during an extended disability. Your needs are special, so call and talk with us. The only time to draw a blank in your insurance is when you fill it in with Blanksteen.



The _____ steen Companies

The Blanksteen Companies 253 Washington Street Jersey City, NJ 07302 201-333-4340 1-800-BLANK-AG
The Blanksteen Companies 161 William Street New York, NY 10038 212-732-9435 1-800-BLANK-AG
The MEDICAL SOCIETY OF NEW JERSEY endorsed plans, including Professional Overhead Expense underwritten by National Casualty Company.

SEP 03 1999

AUSTIN, TEXAS

Newswatch

Who's minding the policy for drugs and health care?

New anti-inflammatory agents, a popular drug to treat impotence, HIV combination therapies, and enhancements to the armamentaria for addressing depression, stroke, cancers, Parkinson's, and numerous other diseases and disorders are all making their way into patient care. These technologic advances constitute cause for celebration, especially in New Jersey, the nation's "medicine chest." But, as usual, the economics-minded analysts of the health care sector find gloom amid the sunshine.

It seems that the average cost of drug claims per employee rose 17.5 percent last year, according to a Segal Co. survey noted in *Perspectives on the Marketplace*. The newsletter quotes a Coopers & Lybrand analyst as observing that patients are lobbying legislatures and physicians for access to desired medications, a trend that is supported by direct consumer advertising by pharmaceutical manufacturers.

Meanwhile, billions of dollars in health care bills could be saved—judging from a Merck-Medco study that won the outstanding poster presentation award at this year's American Geriatrics Society meeting, according to *Medicine & Health*—if physician prescribing practices were monitored more closely by pharmacists trained in geriatrics. Presumably, physicians also could generate such savings.

It is not simply that the elderly obtain too many drugs. A potential scandal is erupting over terminally ill nursing home residents' lack of access to pain medications. Generally, pain management is widely recognized as a frontier for concerted and aggressive action, with a state legislative commission, New Jersey HealthDecisions, and at least two state departments attempting to facilitate dying patients' access to more liberal pain control regimens.

Prescribing authority of nurse practitioners and physician assistants has come before the Legislature this year, and efforts to obtain compromises involving the authority to prescribe scheduled drugs have floundered so far.

Other drug-related issues include HMOs' use of Drug

Enforcement Administration numbers in developing physician profiles, and the perennial New Jersey problem of paying for the popular Pharmaceutical Assistance for the Aged program. Access to non-formulary drugs now is a federal issue, addressed by the Democrats' patient rights bill.

Drug control is a formidable regulatory challenge in our state. Recently, the Drug Control Unit of the Division of Consumer Affairs advised prescribers to add any schedule that was omitted from a prescriber's controlled and dangerous substance registration renewal application.

Pharmacy manufacturers attach a high value on physician relations. Pfizer, for example, is circulating results of a survey conducted by Yankelovich Partners for the Pfizer Medical Humanities Institute that shows that three-fifths of patients are extremely satisfied or very satisfied with their physician's performance in communication, accessibility, and followup.

In other arenas, such an impressive array of related problems would point the way toward the attempted development of a comprehensive policy. But, drugs are such a broad topic that no one, to

date, has suggested the establishment of a New Jersey Commission on Drug Policy.

Physician-patient relations were recognized, though, when the state Senate passed S-799, which would permit certain types of patients to continue seeing a physician who has left the patient's health plan. The bill covers life-saving care, postoperative care, oncologic care, psychiatric care, and obstetrics.

The "ex-network physician" bill was sponsored by Senator Jack Sinagra of Edison, chair of the Senate Health Committee. News that Sinagra won this year's Nathan Davis award of the AMA was greeted with loud applause at a June 11 hearing of his committee.

In general, the role of state governments in crafting health care policy has come under a microscope. The failure of the Clinton health plan five years ago fed hopes that states would solve problems in access to health insurance. Writing in *Health Affairs*, Columbia University School of Public Health professor Michael Sparer argues that such hopes are poorly grounded. States, Sparer contends, are achieving successes only where there is a federal framework, as in child health insurance.

There may be a new data brouhaha brewing on the federal level, and *Medicine & Health Perspectives* compares the situation to the Health Care Financing Administration's problems with hospital mortality data. The General Accounting Office (GAO) implicitly has faulted HCFA for not releasing comparative data on HMOs' disenrollment rates.

Because most health plan subscribers give high ratings to their plan, disenrollment rates have emerged as the key measure of patient dissatisfaction. HCFA consistently has been collecting such information on Medicare HMOs and, just as consistently, recoils from issuing it.

This spring, the GAO provided the Senate Aging Committee with disenrollment data that revealed a wide spread among Medicare HMOs. Twenty of the 194 health plans studied produced annual rates above 30 percent, while one-half came in under 10 percent. Measurement issues include whether to set a minimum period (such as two months) that a person must be in an HMO before being counted, and whether to include "administrative" disenrollments occasioned by a person's move out

of the market area or other need to leave a plan.

On July 23, the New Jersey Hospital Association and three other statewide health care organizations will sponsor a meeting on "Care Management and Discharge Planning across the Continuum." When patients are transferred among hospitals, nursing homes, homes, and other settings, all members of the health care team must cooperate around a general plan of care.

Curiously, physicians are not listed as a target audience for the care management meeting. Perhaps the meeting planners saw physicians primarily as mere prescribers. Let's hope that some physicians will participate, anyway.

New Jersey's delegation continued to exercise clout at the AMA Annual Meeting in June. Chaired by Irving P. Ratner, MD, the MSNJ delegation led efforts to improve Medicare evaluation and management procedure coding, assure that future AMA top executives will not be AMA political insiders, improve the wording of ethics standards, and secure the benefits of the American Medical Accreditation Program.

Neil E. Weisfeld

“I KNOW NO
WAY OF JUDGING
THE FUTURE
BUT BY THE PAST.”



PATRICK HENRY, 1775

As a Princeton Insurance Company policyholder, your professional and financial future isn't written in the stars, but in the history books: Princeton has had a long-standing commitment to meet the professional liability insurance needs of doctors. That includes a track record of vigorously defending our insureds against frivolous malpractice claims and a rate structure that rewards doctors with good experience.

To help secure *your* future, consult one of the independent agents who represent Princeton or call us at **1-800-433-0157**.



Princeton Insurance Company

Professional Liability

Office Package Policy

Workers Compensation

Rated A- (Excellent) by A.M. Best Company 746 Alexander Road • Princeton, New Jersey 08540

SKILLED HANDS.



Trust your most delicate advertising challenges to the marketing communications experts at Three Bears. We get it "just right" for the newly re-designed New Jersey Medicine magazine, and we'll be glad to hand creative solutions to you, too.



THREE BEARS

ADVERTISING • MARKETING COMMUNICATIONS

20 NASSAU STREET, PRINCETON, NJ 08542
609-688-1400

NEW JERSEY MEDICINE

JULY 1998

Editor-in-Chief **Howard D. Slobodien, MD**
Executive Editor **Geraldine R. Hutner, MA**
Assistant Editor **Nancy M. Propsner, BA**
Editorial Assistant **Karen Cuzzo, BS**
Advertising **Cookson Media Services**
Production **Trenttypo, Inc.**
Graphic Design **Three Bears Communications**
Cover Photo **Conrad Gloos**

President and Chair **R. Gregory Sachs, MD**
President-Elect **Irving P. Ratner, MD**
First Vice-President **Walter J. Kahn, MD**
Second Vice-President **Angelo S. Agro, MD**
Secretary **Bessie M. Sullivan, MD**
Treasurer **Eileen M. Moynihan, MD**
Immediate Past-President **Carl Restivo, Jr, MD**

MEDICAL SOCIETY OF NEW JERSEY BOARD OF TRUSTEES

S. Manzoor Abidi, MD
Stevan Adler, MD
Churchill L. Blakey, MD
Donald J. Cinotti, MD
Rajendra Prasad Gupta, MD
George T. Hare, MD
David A. Ingis, MD
Philip J. Jasper, MD
Elliot M. Kraus, MD
Giovanni Lima, MD
Mark T. Olesnick, MD
Robert S. Rigolosi, MD
Andrew Kunish, MD, *Speaker of the House*
John W. Spurlock, MD, *Vice-Speaker of the House*
Francis J. Lumia, MD, OMS
Jamsheed K. Najmi, MD, *Medical Specialty Societies*
Sean C. Reinhardt, *Medical Student*
Niranjan V. Rao, MD, *Member-at-Large*
Michael J. Spedick, MD, *Member-at-Large*
Valerie Claps, *MSNJ Alliance*
Carlo Porcaro, MD, *IMG Section*

REVIEW BOARD

Sofia Anthony, MD, Paul W. Armstrong, Esq.,
Richard M. Ball, MD, Stanley S. Bergen, Jr, MD,
Harry M. Carnes, MD, Gary S. Carter,
Elizabeth G. Christopherson, Ellen M. Cosgrove, MD,
The Honorable Len Fishman, Joseph E. Gonzalez, Jr,
Paul J. Hirsch, MD, Ismail Kazem, MD,
Louis L. Keeler, MD, Carol J. Kientz, RN,
James R. Knickman, PhD, Paul R. Langevin, Jr,
George R. Laufenberg, Martin S. Levine, DO,
Henry R. Liss, MD, Gregg Lubinsky, RPh,
Ruth B. Mandel, Michael R. McGarvey, MD,
Julane Miller, Charles M. Moss, MD,
Patricia Murphy, PhD, RN, Tom O'Neill,
Fred M. Palace, MD, Mary Todd, DO,
William H. Tremayne, F. Kevin Tylus,
The Honorable Charlotte Vandervalk,
Joan Verplanck, Paul E. Wallner, DO

Practicing medicine
= good

Practicing running
a business
≠ good

*Practice management and
practice efficiency solutions
from professionals with
hands-on experience*

WITHUM, SMITH & BROWN
Certified Public Accountants & Consultants
Health Services Department

100 Overlook Center

Princeton, NJ 08540

609-520-1188

<http://www.withum.com>

Offices in New Jersey and Pennsylvania



MEMBER NEXIA INTERNATIONAL
A WORLDWIDE NETWORK OF
INDEPENDENT ACCOUNTING FIRMS



**100% NO
LOAD**

HIGH YIELDS FOR MONEY FUND INVESTORS

**Current
7-Day Yield[†]
5.24%**

T. Rowe Price Summit Cash Reserves Fund

helps you get the most
out of your liquid
assets. With a 7-day
yield of 5.24% vs. 5.02%

for the IBC Taxable Money Fund Average,
the fund offers a highly attractive income
opportunity.* The fund invests in high-
grade, short-term money market securities
for high income while offering a stable
\$1.00 share price. Also, because the
Summit Cash Reserves Fund offers free
checkwriting,** it can serve well as a
working capital account.

**High income from a low-expense
strategy.** Summit Cash Reserves provides
high yields in part by passing on to you
the savings resulting from low fund
expenses. The fund's minimum initial
investment of \$25,000 allows it to operate
at a high level of efficiency, which means
lower expenses for the fund and, there-
fore, potentially higher earnings for the
investor overall. And, unlike other low-
expense funds, we charge no additional
fees for any of our services. The fund's
yield will vary with interest rate changes.
No sales charges.

**Call 24 hours for your free
Summit investment kit
including a prospectus**

1-800-541-2490

www.troweprice.com

Invest With Confidence

T. Rowe Price



[†]Simple yield as of 6/5/98. Past performance cannot guarantee future results. Unlike bank products, the fund is neither FDIC-insured nor guaranteed by the U.S. government, and its yield will fluctuate. *There is no assurance the fund will be able to maintain the \$1.00 share price. **\$500 minimum. Read the prospectus carefully before investing. T. Rowe Price Investment Services, Inc., Distributor.

SCR042765

22

Focus on health care

Glove story: Problems on their hands

What happened to those seemingly innocuous latex gloves? The answer lies not so much in their use, but in how they are made. Read about what happens when gloves and hands don't mix.

28

Special feature

Who are the uninsured?

One fact has failed to make it to the public: there are over 1.3 million New Jerseyans who lack health care coverage. Who is to blame? Who can help?

33

Public health advances

Tourette: Sights and sounds

While physicians are struggling to understand a disease called Tourette syndrome, the insurance industry is categorizing the medical condition.

37

Clinical report

Patterns of care: Stage I carcinoma of the endometrium

Endometrial cancer is the fourth most common cancer in females. The risk factors, which include unopposed estrogen use, late menopause, and long-term tamoxifen use, are noteworthy.



Mansue on the uninsured.



Fanelle on endometrial carcinoma.



Pickens on the new physician workforce.

Direct AccessSM

for small employers

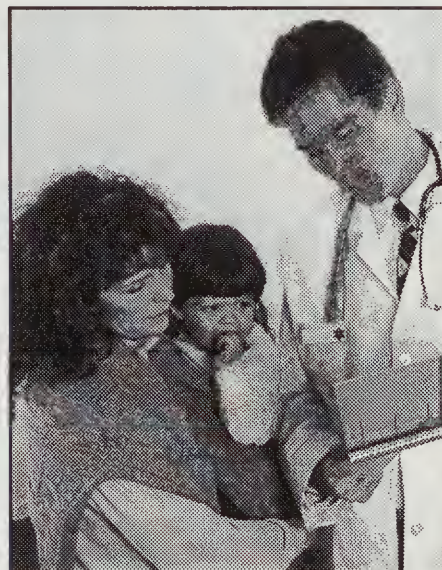
Visit a specialist
without a referral.

Nationwide access to over 300,000
participating doctors, specialists and hospitals.

Value added discounts for you and your employees from
the Vision and CompUSA.

and, announcing a \$25,000 *life insurance program* for small
employer groups that join the MSNJ/BCBSNJ program!

is and more is available when you choose the new
Direct Access health plan from Blue Cross and Blue Shield of
New Jersey—The Medical Society of New Jersey's health
carrier of choice for its members!



BlueCross BlueShield
of New Jersey

INDIVIDUAL &
SMALL EMPLOYER
DIVISION

Ask us for a free
copy of the SEH
Buyer's Guide.

For more information on Direct Access, and other
health plans for individuals, families
and small employers,
contact the Medical Society of New Jersey's
exclusive BCBSNJ representative:

Medical Society of New Jersey
MSNJ

Jennifer Altobelli
Sales Representative
973-338-0893

43 In the spotlight

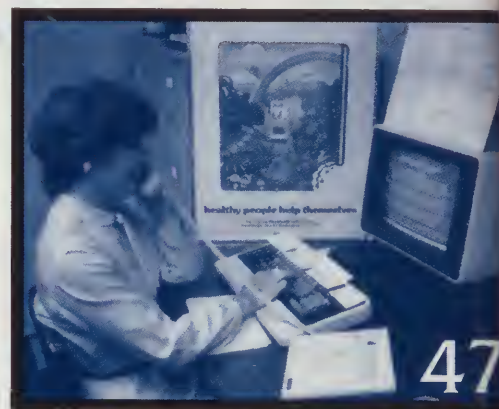
Robert L. Pickens, MD

As chair of the New Jersey Commission on the Physician Workforce, Dr. Pickens is working to understand ways to help maximize productivity, quality, fairness, opportunity, and access in health care.

47 Commentary

Clearing the way for self help

Curing patients no longer is all that needs to be done to help ensure recovery. Self-help groups add a new dimension to health care. The New Jersey Self-Help Clearinghouse, located in Denville, is a good place to start.



Support systems from the New Jersey Self-Help Clearinghouse help patients recover.

51 Current trends

New drugs for cancer

Advancements in cancer include new agents, modifications of established treatments, and modulation of host-immune response. The outlook for cancer patients is enhanced by new treatments every day.

DEPARTMENTS

1 Newswatch

The cost of drug claims and drug control. Do we need a commission? AMA news.

10 Mail Stop

The real burdens of HMOs; evaluation and management coding guidelines.

15 Editor's Notes

Look at what DRGs have spawned: E&M coding guidelines.

20 Online @ MSNJ

Check out MSNJ's improved web site; who cares about the weather; instant messages around the clock.

56 Calendar


Current listing of medical meetings and conferences around the state in the fall.

61 F.Y.I.

Programs and people for all seasons; Sinagra honored by the AMA.

64 Photo Finish

Another side of life in the emergency room; the personal side to medicine.



“Can I **increase patient satisfaction and referrals at our facility?”**

BRACCO SAYS YES!

Exclusively for Bracco customers: The unique Patient Assessment of Services Satisfaction (PASS™) program provides information and resources for staying competitive in the managed care marketplace.

These confidential surveys reveal how patients perceive all aspects of your radiology department, from the atmosphere in the waiting room to the courtesy of your technologists. Quarterly PASS™ reports let you track service strengths and weaknesses. And Bracco offers solid resources for positive change, so you can improve your competitive edge—and market share—versus other facilities in your community.



DIAGNOSTICS

THE CONTRAST IS GREATER WITH BRACCO

The real burdens of HMOs

In the April Newswatch, a report from *Medical Economics* was cited that indicated "physicians expend only 3 percent of their work week on insurance paperwork, regardless of their degree of involvement in HMOs." The implication of this statement was that the shift to managed care did not create intolerable paperwork burdens for physicians.

Now that I think of it, I believe that this overly simplistic statement may be true. Now that my practice has taken on an HMO character, I do find myself spending actually less time on preparing and signing insurance paperwork than I used to spend.

However, in its place, my managed care involvement has created a much more virulent monster. I spend many more cumulative hours per week trying to explain to patients why some of their treatments have to be delayed, why they can't go to the x-ray or laboratory facility that is best and/or most convenient for them, why their laboratory results have not yet been reported, and why they can't be referred to a particular specialist that they prefer. In addition, I have to be on the telephone at least once a week with a medical director or precertification person explaining a procedure I want to do for a patient or complaining about a decision.

What about the fact that my two-man practice now has two people instead of one sitting at the

appointment desk, one and a half bookkeepers instead of one taking care of the business end of things, two nurses instead of one doing the work of scheduling and preparing patients for surgery, and we still feel understaffed and find it hard getting all the work done? Does it matter that our accounts receivable has grown due to HMOs not paying on a timely basis?

Yes, there are some benefits to patients and to doctors, but in the long run, time "wasted" on HMO affairs, alterations of practice philosophies to conform to HMO idiosyncrasies, huge decreases in reimbursement rates for office visits and operative procedures, and significant increases in personnel and administrative expenses are the real burdens and impacts of being involved with HMOs. How much time we spend signing insurance forms is irrelevant. When is someone going to address the real issues?

H.S. Farmer, MD

E&M coding

I read with interest the article by Drs. Moynihan and Restivo concerning the refining of evaluation

and management codes. I agree that the new guidelines for physical examinations are burdensome and sometimes inappropriate for individual patients. As you probably know, the 1995 guidelines allowed the physician to choose those parts of an organ system to examine. The clinician was able to determine whether the examination of one section of the body was complete. The 1998 guidelines mandate that certain parts of each organ system be examined, even if they are irrelevant. I applaud the MSNJ efforts to alter those rules.

Although there may be a repeal or change in the physical examination guidelines, HCFA has not changed the definition of a complex history or process of making a medical decision. Many physicians have not yet embraced the fact that both HCFA and other insurers have recognized that physicians need to better document the work provided during patient encounters. Many physicians have not grasped the concept that they are primarily responsible for all coding decisions and allow their staff to decide on the level of visit to be billed.

Physicians must face the reality: Our charts generally have not reflected the work performed, and we will not receive higher reimbursement until documentation improves. We need to expend positive energy to improve charting while we ask HCFA to make the rules easier to understand.

David L. Blecker, MD, MPH

Requirements for letters

To submit a letter, fax (609.896.1368), e-mail (info@MSNJ.org), or mail your letter to New Jersey Medicine, Two Princess Road, Lawrenceville NJ 08648. Letters should be typed and double-spaced and should be no longer than 400 words with 4 references, if necessary. Include your full name, affiliation, address, and telephone number.

Letters are published at the discretion of the editor-in-chief and are subject to editing and abridgment. Letters may be published on MSNJ's web site, <http://www.msnj.org>. Financial associations or other possible conflicts of interest must be disclosed. Letters represent the opinions of the authors.

Whether it's an alcohol or drug problem, count on Sunrise House for expert help.

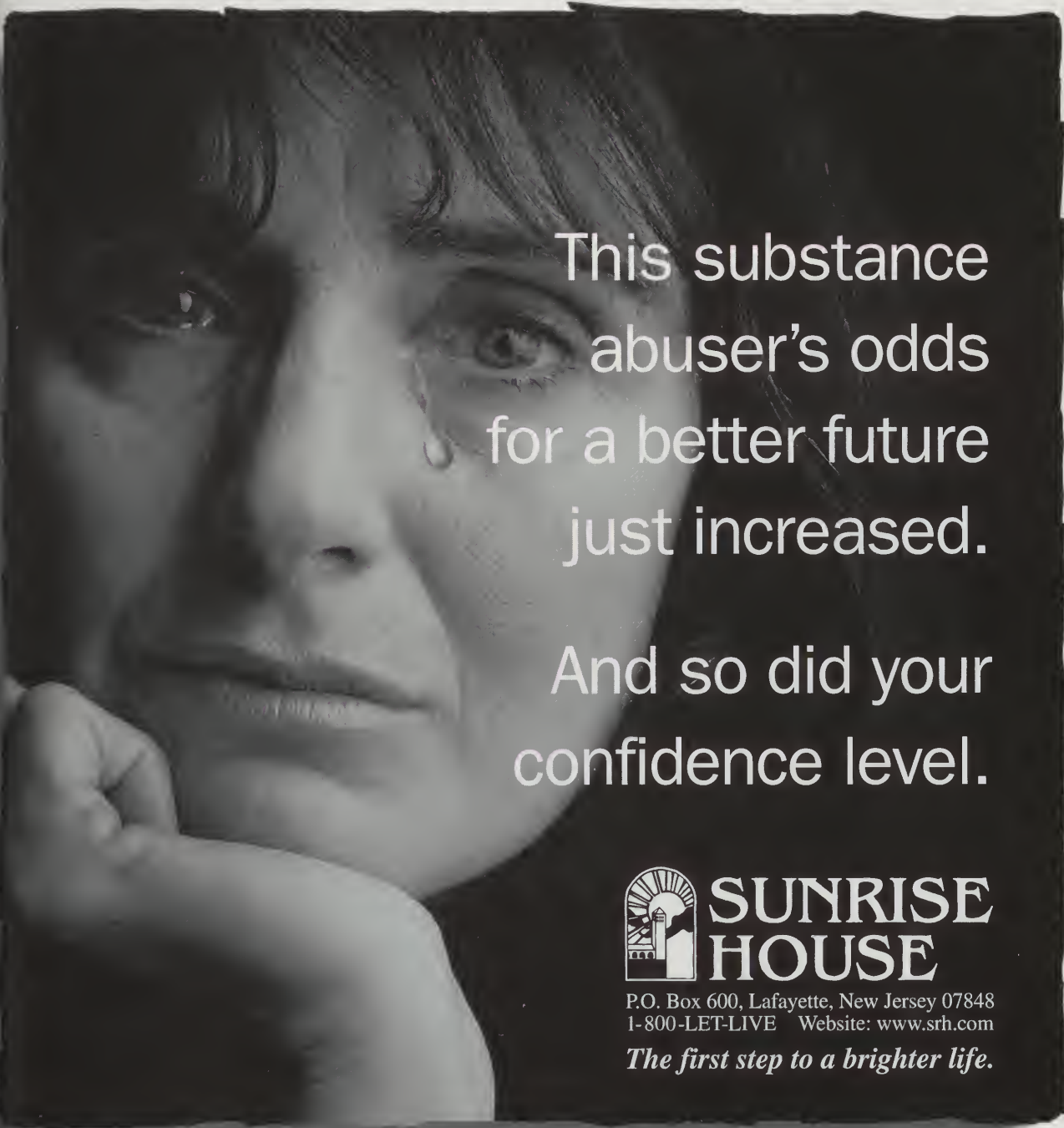
For 14 years, hundreds of tri-state area doctors have trusted us to offer their patients the most effective, caring treatment and a chance for a better life.

Set in the scenic hills of northwest New Jersey, we're a licensed, nonprofit specialty hospital with a nationally known commitment to quality—including Accreditation with Commendation by the JCAHO.

Our comprehensive programs include inpatient and outpatient services, after-care and family support.

And our experienced staff of doctors and specialists works closely with referring physicians to ensure continuity of care at every stage of treatment.

Sunrise House. High-quality, affordable treatment you can trust. For information, call us at 1-800-LET-LIVE or (973) 383-6300.



This substance
abuser's odds
for a better future
just increased.

And so did your
confidence level.



**SUNRISE
HOUSE**

P.O. Box 600, Lafayette, New Jersey 07848
1-800-LET-LIVE Website: www.srh.com

The first step to a brighter life.

Sunrise House is a preferred provider of most major insurance companies and HMOs.
We will process insurance benefits verification and precertification.

Cancer genetic testing

Cancer is a genetic disease. Recent advances in genetic research presage a deeper understanding of the molecular mechanisms that govern cell replication and growth and provide illuminating insights into improved methods of disease control. The Human Genome Project is a major effort to map the entire human genetic apparatus, one that will provide the key to unlock the codes responsible for producing the malignant condition.

Some of the important new findings thus far include: identification of the BRCA1 and BRCA2 genes, leading to the introduction of commercially available tests to find individuals at increased risk for breast and ovarian cancers;¹⁻³ development of genetic tests for familial forms of melanoma, retinoblastoma, and Wilm's tumor;²⁻⁵ isolation of possible genes for inherited forms of prostate cancer, certain leukemias, and renal cell cancer;^{2,3,7,8} and determination of two main forms of hereditary colon cancer: familial adenomatous polyposis and hereditary nonpolyposis colorectal cancer.^{2,3}

While the scientific understanding of genetic testing has accelerated, numerous questions have arisen regarding the psychosocial, legal, and ethical implications of this knowledge. Issues to be addressed include loss of privacy, discrimination, and dilemmas created by incomplete understanding of information.

Because of these risks, federal and state legislative initiatives have been created to provide protection of individuals. In New Jersey, Governor Whitman signed, in

November 1996, the Genetic Privacy Act (P.L. 96, C.26). This law regulates genetic testing, including the acquisition, disclosure, and retention of information obtained from genetic tests. This Act has been described as one of the strongest in the country.

As events unfold, clinicians need to become educated regarding genetic issues and the implications for patient care. An important aspect of this activity will be the informed consent process, one intended to assist patients in dealing with complex information and providing a process to gain access to counseling services to amplify and explain findings.

In 1997, the New Jersey Commission on Cancer Research surveyed oncologists and obstetricians/gynecologists to ascertain the educational needs of clinicians in dealing with the emerging issues surrounding genetic testing. The results indicate that professional education for practitioners is an important priority for the state.

The Commission is working in conjunction with other professional agencies to develop regional training programs. Various groups will be offering continuing education programs. Clinicians are

encouraged to participate in these programs to enable them to deal with the complex challenges posed by cancer genetics.

Alan J. Lippman, MD
Section Director, Medical Oncology,
Newark Beth Israel Medical Center;
Member, MSNJ Council on
Communications

Ann Marie Hill
Executive Director, New Jersey
Commission on Cancer Research

REFERENCES

1. BRCA1 sequence analysis in women at high risk for susceptibility mutation. *JAMA* 27B: 1242-1250, 1997.
2. Gould R, Lynch HT, Smith R, McCarthy J: *Cancer & Genetics*. PRR, Huntington, NY, 1997.
3. Fearon ER: Human cancer syndromes. *Science* 278:1047, 1997.
4. Lohmann DR, et al.: Molecular analysis and predictive testing in retinoblastoma. *Ophthalmic Genetics* 16:135-142, 1995.
5. Liu Z, Song Y, Bia B, Cowell JK: Germline mutations in the RBI gene in patients with hereditary retinoblastoma. *Genes Chromosome Cancer* 14:277-284, 1995.
6. Wuesnel S, Malkin D: Genetic predisposition to cancer and familial cancer syndromes. *Ped Clin NA* 44:791-808, 1997.
7. Peters G, et al.: Regulation and function of the cyclin-dependent kinase inhibitor p16CDKN2. International Association for Competitive Research on Leukemia and Related Disease, 1995.
8. Decker HJ, et al.: Meeting Abstract, Sixth International Workshop on Chromosomes in Solid Tumors. Tucson, AZ, 1995.

Requirements for letters

To submit a letter, fax (609.896.1368), e-mail (info@msnj.org), or mail your letter to New Jersey Medicine, Two Princess Road, Lawrenceville NJ 08648. Letters should be typed and double-spaced and should be no longer than 400 words with 4 references, if necessary. Include your full name, affiliation, address, and telephone number.

Letters are published at the discretion of the editor-in-chief and are subject to editing and abridgment. Letters may be published on MSNJ's web site, <http://www.msnj.org>. Financial associations or other possible conflicts of interest must be disclosed. Letters represent the opinions of the authors.

YOUR PRACTICE HAS CHANGED SIGNIFICANTLY. SO WHY HASN'T YOUR PRACTICE INSURANCE?

Traditional policies for medical practices are not tailored for you. In fact, the same insurance policy you currently use covers everything from a shoe store to a pizza parlor. Does that sound logical?

The Woodland Group has changed the concept of insuring a medical practice. Today, your medical practice can be protected by The Woodland Alliance Profile, a Risk Management Group created exclusively for physicians offering. . .

- Practice-specific coverage that has and will continue to evolve as the medical industry changes, covering everything from office property and patient charts to diagnostic equipment, general liability and workers' compensation.
- An opportunity to share in profitability of the Risk Management Group through profit sharing returns.

Put Yourself in the Hands of a Specialist.

Call us at **1-800-253-1521** to learn more about The Woodland Alliance Profile or check our website at **www.woodlandgroup.com**.

***The Woodland Alliance Profile...
coverage that is as evolutionary
as your practice.***



- Medical Malpractice
- Managed Care Liability
- Group Disability
- Group Term Life
- Homeowners/
Automobile



1-800-253-1521

<http://www.woodlandgroup.com>

We know that practicing medicine is your primary concern.

The professionals at Healthcare Management Partners will take away the time-consuming administration and pressures of billing, collections, follow-up, office management, and system maintenance, so you can concentrate on doing what you do best - practicing medicine.

Contact Rosalie Fox or Robert Rahl at 609-734-0443 to find out more.

**Practice Assessments • Billing & Collection •
MIS Systems • Group Practice Formation •
Practice Management • Income Distribution**

**Endorsed Computerized Billing,
Accounts Receivable and
Information Management Company of the
Medical Society of New Jersey**



HEALTHCARE MANAGEMENT PARTNERS

PARTNERS IN PROFIT

200 Canal Pointe Boulevard • Princeton, NJ 08540-5998
609-734-0443 • FAX 609-243-9799

A Division of Health Information Consulting Services, Inc.

Look at what DRGs have spawned

The 1998 Annual Meeting of the House of Delegates of the Medical Society of New Jersey (MSNJ) contained its usual mélange of resolutions. Among them were those dealing with unions, with single payor plans, with accountability of insurors, and with our right to waive co-payments and deductibles without penalty.

But much of the concern and debate centered on evaluation and management (E&M) coding guidelines—eight resolutions having been submitted—and we urged the AMA to continue its efforts to obtain changes in these oppressive, unfairly punitive rules. George T. Hare, MD, professor of clinical medicine and head, Division of Geriatric Medicine at UMDNJ—Camden, gave a verbal report of the recent meeting in Chicago on that topic. At my request, he also has documented the salient points of that meeting. The text of his letter follows:

"On April 27, 1998, there was a meeting at the Marriott O'Hare

to discuss the E&M codes and documentation guidelines. I attended this meeting to represent MSNJ. There were 300 physicians and ancillary personnel present.

Attending the meeting were Dr. Perry Wooten, AMA president; Nancy Dickey, MD, AMA president-elect; Thomas Reardon, MD, chair, AMA Board of Trustees; T. Reginald Harris, MD, chair, CPT Editorial Panel; Robert Berenson,

MD, director, Center for Health Plans and Providers, Health Care Financing Administration; Joseph E. Vengrin, assistant inspector general for Audit Operations, HHS Office of the Inspector General; and Douglas E. Henley, MD, member of the Executive Committee, CPT Editorial Panel. In addition, there were other members, both from HCFA and the AMA, who were part of the breakout sessions.

Howard D. Slobodien, MD



The only thing that saves us from the bureaucracy is inefficiency. An efficient bureaucracy is the greatest threat to liberty.

Eugene J. McCarthy, in *Time*, 1979

The AMA and HCFA noted that sending out the 1997-1998 guidelines was a mistake and that a pilot study should have been conducted. Dr. Wooten presented his feelings on this matter; they conformed nicely with many of the remarks that were prepared for the open session, including mine.

The facts that came out of this meeting are as follows:

1. There is no definite timetable for the institution of the E&M codes and documentation guidelines.

2. Specialty societies and the practicing physicians again will be contacted for comments and recommendations regarding the changes necessary to make this an acceptable document.

3. The document will be shortened, simplified, and made more user friendly.

4. Vignettes will likely be requested from each of the specialty societies to obtain a baseline for what represents a Level 5, Level 4, etc. They believe that this will help them better understand the coding and documentation.

5. During the coming months there should be meetings and discussions with the specialty societies as well as with practicing physicians regarding recommendations for the guidelines.

6. Following the completed work, and with agreement by the physicians that the codes are acceptable and usable, there will be pilot studies. How these will be accomplished was not determined at the end of the meeting, but suggestions were given as to how they should work, such as: audit the charts of a specialist or primary care physician by another peer, along with a representative from the carrier. This would not be an audit in any punitive manner, but would represent one of the most important aspects of the work to come—education. It would help physicians learn how to evaluate themselves and how to comply.

7. The documentation for reimbursement must be in close proximity to what the practicing physician documents in the chart for the care

Bureaucracy, the rule of no one, has become the modern form of despotism.

Mary McCarthy, *On the Contrary*, 1961

of the patient. We pointed out that the notes we write usually are succinct and represent quality, and it should be unnecessary for us to double or triple the amount of information in order to be in compliance with the E&M and documentation codes.

8. HCFA has notified their carriers that they may use either the 1994-1995 or 1997-1998 coding system, whichever is more favorable to the physician, until the revisions have been completed and there has been adequate time for testing and education. This was stated verbally by the HCFA representative, Dr. Berenson, and also was written in a letter from Nancy-Ann Min DeParle, administrator for Health and Human Services.

9. Mr. Vengrin noted that the Office of the Inspector General would not establish its own guidelines for evaluation, but would rely upon the carrier before any investigation was carried out. There had to be a pattern, one of recklessness that

demonstrated abuse and potential fraud of the system.

Finally, I would like to state that this is not the end of the E&M code and documentation problem. It is not going to go away unless Congress deems it so. Therefore, we must take part in the future deliberations and make our comments and recommendations known. We must be aware of what our specialty societies are suggesting and that the guidelines do not represent the non-full-time practicing physicians' recommendations. We must continue to keep pressure on the AMA and HCFA and be certain that what the final documentation represents is that of the practicing physician who provides the care and quality necessary for our patients.

I hope to continue to stay involved in this activity and have volunteered to do so. I will certainly try to keep everyone apprised in regards to anything that the future holds for use in the practice of medicine. A web address is available on the Internet for additional information: <http://www.ama-assn.org/emupdate/flyin/press001.htm>.

Thank you, George! We appreciate your efforts on our behalf. Please continue.

Question: Is the surgeon who takes two hours for an operation twice as good as the surgeon who takes one hour?

John Paul Dizzia, P.C.

ATTORNEYS AT LAW

Legal Counseling and Representation to Medical Professionals in administrative, regulatory and disciplinary matters before the State Board of Medical Examiners, the Department of Insurance, the Division of Medical Assistance and Health Services, and in the law relating to professional rights, responsibilities, ethics and practice issues.

Member:

- National Health Lawyers Association
- Health and Hospital Law Section, New Jersey Bar Association
- New Jersey Association of Professional Mediators

108 North Union Ave.
P.O. Box 886
Cranford, N.J. 07016

Call: (908) 276-6111
FAX: (908) 276-5838
E-Mail: JPDLaw@WORLDNET.ATT.NET

I HEAL DOCTOR'S OFFICES. TELL ME WHERE IT HURTS!



Mary Ann Hamburger has triumphed as the most comprehensive and efficient single source for medical office set ups and reorganizations. She is an expert in every detail of office administration, from personnel hiring and training, to phone systems, billing and collections, to CPT and ICD updates. Mary Ann is expert in third-party payments, setting fee schedules, and the selling of medical practices. Mary Ann is dependable. She has the contacts, background and practical know-how to set up or improve your office systems.

Your medical practice is a business, and if that business does not run efficiently, it will affect your patient and public relations. You know what you need, but you don't know how to go about it. Call for a whole new approach to medical office practice.

MARY ANN HAMBURGER ASSOCIATES

THE SPECIALIST'S SPECIALIST

74 HUDSON AVE. MAPLEWOOD, N.J. 07040
973-763-7394

LET'S TALK!

NEED A BUSINESS LOAN?
CALL US FOR...

EXPERT HELP
FABULOUS SERVICE
COMPETITIVE RATES
FAST APPROVALS AND CLOSINGS

Up to approx. \$1,500,000 under the U.S. Small Business Administration Guaranteed Loan Program.
Approvals in 24 hours, or less.
Preferred (PLP) lender in New Jersey, New York and Pennsylvania.



Call 1-800-SBA-2005
ask for the "SBA Specialist"

PRESTIGE STATE BANK

Equal Housing Lender Equal Opportunity Lender

Member FDIC

MAC

Equal Housing Lender

THE RIGHT PRESCRIPTION FOR YOUR CALLERS



Message-On-Hold Systems

Use your telephone music-on-hold feature to:

- Promote Services
- Reassure Callers
- Educate & Inform
- Encourage Referrals

HOLD.COM

Serving the NJ Healthcare Industry Since 1987

Call 1-800-666-6465

<http://www.holdcom.com>



UNPRECEDENTED ACCOUNTABILITY
CONFLICTING PERFORMANCE CRITERIA
MULTIPLE, FRAGMENTED PROCESSES
TIME-CONSUMING
MORE DOCUMENTATION
LESS PATIENT CARE
HIGH COST
DUPLICATIVE OFFICE-SITE REVIEWS
INCONSISTENT CREDENTIALING
NEVER-ENDING PAPERWORK
ADMINISTRATIVE HASSLES

Our solution has arrived.

One Time

One Source

One Standard



American
Medical
Accreditation
Program

The new American Medical Accreditation Program (AMAP), physicians
submit an application **ONE TIME**, have their credentials primary-source
verified **ONE TIME**, and have an on-site office review **ONE TIME**.

AMAP then provides an Accreditation report and certificate to each physician
who meets the AMAP national standard.

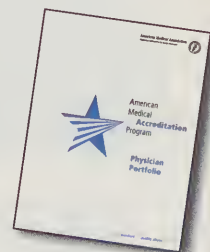
AMAP will provide a complete portfolio of verified credentials, office site
visit and other frequently requested information to each health plan and
employer that uses AMAP and with whom the physician is affiliated.

The American Medical Accreditation Program is a voluntary, comprehensive
accreditation program that measures and evaluates individual physicians
against national standards, criteria and peer performance in five areas:
Credentials, Personal Qualifications, Environment of Care,
Clinical Performance, and Patient Care Results.

Meeting and maintaining AMAP's high standard earns a physician AMAP
Accreditation – a new national benchmark of physician quality.

AMAP, your one source for the new national standard of physician quality
information, has arrived.

To learn more about the many benefits
AMAP has to offer *your* organization,
call the AMAP Resource Center at
1-888-881-AMAP (2627) or visit the AMAP
Web site at <http://www.ama-assn.org>.



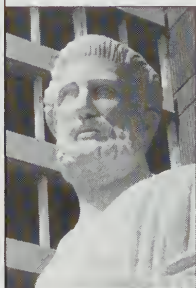
The standard in quality physician care.

American Medical Association
Physicians dedicated to the health of America



A BETTER BYTE OF MEDICINE

We've done it! The Medical Society of New Jersey web site (www.msnj.org) has been redesigned and enhanced—making it more user friendly and more information oriented.



Statue of Hippocrates at Robert Wood Johnson Medical School Campus

With the same address, the new site gives members a greater look inside the organization that works around the clock for its members. And, to help patients deal with the world of health care, the site boasts of an improved Physician Finder, a service for patients to find just the right physician and for physicians to find referrals. This listing of member-only physicians spotlights only MSNJ members. Take a look and visit the site often for member news, legislative updates, insurance bulletins, and articles on health care and health policy.

THE WEATHER DOESN'T MATTER

While the post office will process your letters through snow, sleet, rain, and hail, e-mail doesn't have to check with the weather channel. If

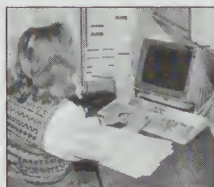
you are looking for a free e-mail account, check out The Free Site (www.thefreesite.com), which offers a cheap and easy way to have multiple accounts for office staff, for family, or for patients. You have plenty of choices for e-mail services, and the sites are free with support from advertising.

YOU CAN GET THERE FROM HERE

Did you know that the MSNJ Physician Finder (www.msnj.org) offers a map to show the way to a member-physician's office? And, if you need directions anywhere else, and don't want to get lost, check out these Internet web sites for your trip planning needs: www.mapsonus.com and www.mapquest.com.

INSTANT MESSAGE

Do you need to tell your colleague something quickly and you want a reply? But you have different providers. To get your message across, try America



Online's instant messenger. This service lets you send instant messages to

your friends and neighbors on AOL and to everybody elsewhere—without an AOL account and with no cost to you.

BOOKMARKS

www.state.nj.us/health

From senior services to AIDS, from smoking and addiction services to HMO performance, the web site of New Jersey Department of Health and Senior Services offers timely and topical information.

www.carpaint.com

www.autobytel.com

There is more than one way to shop for a new car. Compare makes and models before buying. And check out www.autoconnect.com for a selection of used cars.

www.ndmainfo.org

The Nonprescription Drug Manufacturers Association initiated this site to give providers and consumers a resource for over-the-counter drugs, with a tag line that reads, "Better health through responsible self-medication."

www.landseer.com

From Barnes & Noble to Amazon Books, there is plenty to read out there. For business travelers, Landseer's offers an online bookstore with titles for every facet of business traveling.

www.netwellness.org

This site from the University of Cincinnati offers some excellent information on health care, created and written by health professionals.

Lowest Premiums for Quality Malpractice Insurance

The Joseph A. Britton Agency can help make it happen. If you are a preferred risk¹, you can qualify for preferred rates². We are also the best source for IPA, PHO, and Healthcare network accounts. Compare these annual premiums at occurrence limits of \$1,000,000/\$3,000,000:

Internists	\$ 5,331	• General Surgeons	\$18,453	• Neurosurgeons	\$43,448
Ob-Gyns	\$39,000	• Urologists	\$11,993	• Psychiatrists w/ect	\$ 2,937
Radiologists	\$ 5,331	• Plastic Surgeons	\$23,350	• Anesthesiologists	\$ 8,572

With 30 years experience, the Britton Agency has proven exceptional in packaging malpractice insurance. Our professional staff and size assure you the benefits of specialized, personal service while offering you quality insurance at the lowest cost.

Call today for a free consultation - Start saving tomorrow



Joseph A. Britton Agency, Inc.

Healthcare & Professional Liability Insurance
855 Mountain Avenue, Mountainside, NJ 07092

(908)654-6464 • Fax: (908)654-1422 • 1(800)462-3401

¹Underwriting approval required. ²May need groups of 3 or more depending on specialty.



Excel Business Park
501 Prospect Street
Unit 96
Lakewood, NJ 08701

Phone: 732•886•0600

Fax: 732•886•0911

"The overall effect is total customer satisfaction."

- Medical/Dental Cabinetry
- Nurses Stations
- Reception Desks
- Nourishment Centers
- Medical/Dental Procedure Carts
- Computer Desks
- Monitor Cabinets
- Chart Racks
- Corian® Solid Surfacing
Certified Fabricator #C-5112
- Space Planning/Layout

GLOVE



W

HAT'S HAPPENED TO THESE SEEMINGLY INNOCUOUS LATEX GLOVES RESTS NOT

SO MUCH IN THEIR USE, BUT IN HOW THEY ARE MADE. AND, OF COURSE, THE

FACT THAT HEALTH CARE WORKERS MUST WEAR LATEX GLOVES. WHAT HAPPENS

WHEN THE GLOVES CAUSE MORE PROBLEMS THAN THEY SOLVE?



PROBLEMS on their hands

by Sheila Smith Noonan

Janet Finn knew she had trouble on her hands. Universal precautions hadn't yet been issued, but Finn—a registered nurse on a surgical floor—wore latex gloves anyway. After her shift, Finn's hands were extremely red and weeping, which a dermatologist explained as sweat within the gloves making her eczema much worse.

Finn tried different gloves and eventually carried her own vinyl pair. She also left hospital nursing to work in an oncologist's office. But even with these changes, Finn's problems were far from over. After blowing up balloons, her face, lips, and tongue swelled. Another time, she had an immediate allergic reaction when a dentist wearing latex gloves began his work. "Within ten seconds, I pushed him away," Finn recalls. "My eyes and face started swelling, and that lasted for three days." Even people taking off powdered latex gloves affected her. In 1990, while on a nursing school faculty, Finn stood by as students pulled off their gloves; the

asthmatic went into severe bronchospasm three times. It took a chance encounter with the latex-allergic sister of an oncology patient for Finn to learn that her condition had a name—and potentially life-threatening consequences.

Proteins in natural rubber latex, manufactured from a milky white fluid derived from rubber trees, can bring on allergic reactions, particularly in spina bifida patients, people who have had multiple surgeries, and persons whose jobs repeatedly expose them to latex products, such as health care workers. Potential routes of exposure to these proteins include dermal and inhalation, as well as contact with mucous membranes, says MSNJ member Elissa Ann Favata, MD, an environmental and occupational medicine specialist and internist in Cherry Hill and clinical assistant professor, UMDNJ-Robert Wood Johnson Medical School. "Powdered gloves particularly enhance exposure because the natural rubber proteins bind with the powder particles

allowing more protein to reach the skin and to be dispersed in the air when gloves are changed. Also, there is an increased risk for exposure to latex allergens and associated adverse effects when latex gloves are worn at the time of an underlying hand dermatitis."

Justin Hanley, RN, who works in the emergency room at Robert Wood Johnson University Hospital at Hamilton, has typical symptoms of the majority of latex-allergic patients: an irritant contact dermatitis characterized by red, irritated hands and broken skin. He has tried many kinds of gloves and now, when he wears them, finds powder free or vinyl preferable to powdered latex. "I only wear gloves in situations where there's bodily fluids, but not for things like starting an IV," he adds. "That may be taking a risk, but I wash my hands diligently. It's preferable to having red, inflamed, rashy hands that are painful to me and uncomfortable for my patients."

There are three types of adverse reactions occurring in persons contacting latex products, says Favata. The most common clinical presentation is a nonimmunologic irritant contact dermatitis. This response manifests as dry, pruritic, irritated areas. The other two reactions are immunologically mediated and include: contact dermatitis (Gell and Coombs type IV cell-mediated delayed hypersensitivity reaction to chemical additives) and IgE-mediated (Gell and Coombs type I) allergic response. The former immunologic reaction begins 24 to 96 hours after contact as a vesicular skin eruption, which may progress to an oozing and/or crusted, thickened state in the areas contacted by the latex products. "The latter-IgE mediated allergic responses, although occurring less commonly, are clearly the most potentially serious. Reactions to latex exposure in sensitized individuals, even to small amounts, can result within minutes in urticaria, rhinoconjunctivitis, bronchospasm, or anaphylaxis.

Accordingly, early recognition diagnosis of latex allergy utilizing a detailed, complete medical history and physical exam is essential."

Existing diagnostic tests for latex allergy are not all they should be, some physicians say. "There's only one FDA-approved blood test, which has proved to be somewhat inaccurate," says MSNJ member Stanley R. Lane, MD, an immunologist and allergist with offices in Moorestown and Salem. "Skin tests available now are potentially dangerous, as some people can have severe reactions to them. We need a good, safe skin test that can be done in allergists' offices that can accurately reveal if a patient is latex sensitive." Researchers at Johns Hopkins are in phase 3 of a multicenter trial of such a skin test, which is expected to be completed this year, with FDA approval and marketing to follow.

And while latex protein initially may be the suspected allergen, chemicals added to latex during processing can cause reactions, says Iris G. Udasin, MD, director of medical surveillance at The Clinical Center for Environmental Health at the Environmental and Occupational Health Sciences Institute, which is jointly sponsored by UMDNJ-Robert Wood Johnson Medical School and Rutgers University. "A physician came to see me with typical latex symptoms, but his FDA-approved latex test came back negative," she says. "By using other allergen tests, we learned he was allergic to a preservative used in the gloves he wore. Now he wears latex gloves made without that preservative."

Lane believes more research should be conducted on ways to desensitize people to latex. Meanwhile, both patients and medical facilities have to adjust. "Hospitals

need to identify patients with latex allergies, and then have available rooms and equipment that are relatively latex free," he says. "It's a matter of dealing with a problem where lives are potentially at stake." In addition to gloves, medical equipment that commonly contains natural rubber latex includes blood pressure cuffs, syringes, IV tubing, catheters,

New Jersey dentist Donald Thiel, DMD, uses latex gloves in his practice.

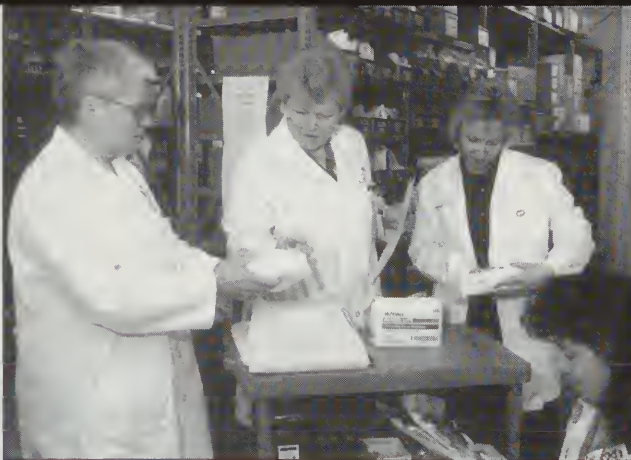


barium enema cuffs, surgical masks, goggles, tops of vials, and rubber aprons.

Some medical facilities, such as the Deborah Heart and Lung Center in Browns Mills, have developed protocols that address needs of both latex-allergic patients and staff, and created a latex-controlled environment. "We've gone

through our equipment to determine what contains latex and from there, what alternatives were available. It was a huge job," says Elaine Fowler, RN, assistant director of nursing in the Department of Nursing Education. "We've found that manufacturers are sensitive to the issue, and many have taken steps to remove latex proteins from their products."

From a treatment perspective, at this time, the best that can be done for people allergic to latex is avoidance,



Deborah Heart and Lung Center's Task Force on Latex Allergy (left to right) includes Patricia Todd, RN; Elaine Fowler, RN; Teresa Walsh, RN.

notes Favata. "Continued exposure to latex can have grave consequences for them," she says. "What starts out as urticaria or rhinitis, over time, can develop into more serious reactions, namely, severe asthma or anaphylaxis."

And so, many latex-allergic people do what they can to avoid natural rubber

latex products. They substitute foil-type balloons for the conventional kind and call restaurants to find out whether food preparation workers wear latex or non-latex gloves. Some won't eat bananas, avocados, papaya, or other fruits and vegetables that have patterns of allergic cross-reactivity. However, people generally cannot control what products are used in their workplaces. And with gloves increasingly being required by employers in non-health industries, such as restaurants, funeral

What's the Matter with Powdered Latex Gloves?

For health care workers who have used powdered latex gloves for years without incident, the debate over latex may seem overblown. What has happened to the seemingly innocuous gloves rest not so much in their use, but in how they are made.

Ever since the emergence of AIDS, and more significantly, OSHA's Bloodborne Pathogen Rule, demand for protective gloves has increased tremendously. According to one estimate, glove use has increased from 500 million pairs annually in the early 90s to about 10 billion pairs a year.

To meet this need, glove makers outsource manufacturing work to other countries, where questionable, time-saving materials and measures may result in latex gloves with high or variable protein levels. During the manufacturing process, latex generally goes through one centrifuging process, which reduces protein content by 50 percent. "If it were done twice, that would reduce proteins another 50 percent, but that's a costly, time-consuming process," says Finn, a latex-allergic registered nurse who lectures to health professionals about latex allergies. "Another problem may be the use of ethylene oxide on rubber trees as a yield enhancer. Ethylene oxide causes sap to come out faster and with higher protein levels."

Among other recommendations, an August 1997 *NIOSH Alert* gives workers the following advice:

- Use nonlatex gloves for activities not likely to involve contact with infectious materials.
- If latex gloves are worn, use powder-free gloves with reduced protein content. When wearing latex gloves, do not use oil-based hand creams or lotions that can cause glove deterioration unless they have been shown to reduce latex-related problems and maintain glove barrier protection.



Janet Finn

homes, and day care centers, there is greater chance for latex exposure in the workplace.

A latex-allergic dentist, Ellen Patterson, DMD, tried unsuccessfully to work in an office that had partially converted to non-latex products. Finally, she opened her own "latex-safe" practice in Fair Haven, where she uses nitrile or vinyl gloves and plastic syringes. Not everyone has that option; for some, a latex allergy requires that they leave their jobs or take different duties.

From an occupational health perspective, the health care industry has been the most closely studied with regard to latex. Scientific literature indicates that 8 to 12 percent of regularly exposed health care workers are sensitized to latex, compared with 1 to 6 percent of the general population. Through the Freedom of Information Act, the national support group, Education for Latex Allergy Support Team and Information Coalition (ELASTIC), acquired data from MedWatch, the FDA's voluntary products reporting program for health professionals. From about 1987 to June 1996, there were 2,323 reports of incidents that workers associated with latex, including 28 deaths, according to ELASTIC's summary.

Udasin and Gail Buckler, RN, MPH, assistant director of occupational health at The Clinical Center for Environmental Health, are conducting research. In July 1997, they surveyed 6,200 members of the Health Professionals and Allied Employees union, most of whom are nurses, to measure the frequency and severity of latex allergy. "Once we determine how much a problem latex allergy is, the next question is how resources should be allocated to address it," says Udasin, the principal investigator.

Preliminary findings reflect statistics similar to those reported in other studies: 93 percent reported having worn latex, vinyl, or other barrier gloves; 13.4 percent believed they

have health problems attributable to latex; and the most frequently reported problem was skin rash/dermatitis, followed by runny, itchy, blocked nose; runny, itchy eyes; and asthma; and 14 people reported anaphylaxis.

There's been action in governmental arenas as well. Under an FDA ruling, all latex-containing medical devices must be labeled by September 30 with the warning, "Caution: This Product Contains Natural Rubber Latex, Which May Cause Allergic Reactions." Manufacturers no longer will be allowed to label reduced-latex products as "hypoallergenic," a claim that can be misleading. And while not imposing a ban on powdered latex gloves, the FDA has promised to write rules to minimize their danger.

Earlier this year, the state Department of Health and Senior Services approved the formation of a task force on latex allergy. Among the group's priorities will be education, most likely through a pamphlet or slide presentation, says Kathleen O'Leary, director of occupational disease and injury services in the Division of Environmental and Occupational Health. Already, the group has helped distribute copies of the August 1997 NIOSH Alert, "Preventing Allergic Reactions to Natural Rubber Latex in the Workplace," to health care institutions. (See the F.Y.I. section on page 61 to request a free copy of the booklet.)

Measures such as these and the medical community's increasing attention to latex sensitivity are welcomed by people such as Margaret Corso, northern representative of the New Jersey ELASTIC chapter. She has heard

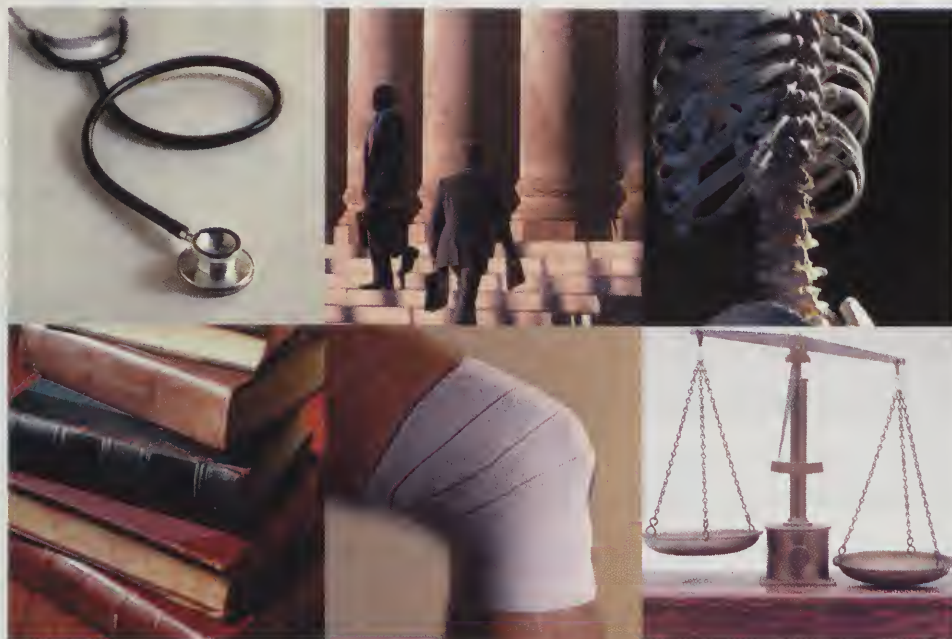
many stories of people who no longer can work in the professions for which they trained because of latex allergy. Corso considers herself fortunate. Moderately affected by the allergy, she still works part time as a substitute dental hygienist.

"I've learned my limits," she says. "But when you talk about degrees of latex allergy, it's like asking someone, 'How pregnant are you?' You never know what's going to put you over to a severe reaction."

More research needs to be conducted on ways to desensitize people to latex, according to Lane.



Critical Treatment for the Future of Your Practice...



Before It's Too Late

Wilentz, Goldman & Spitzer's Health Care Law Practice Group serves health care professionals regarding: group practice formation and operations; management service organizations (MSOs); physician practice management companies (PPMCs); managed care contracting; physician-hospital organizations (PHOs); independent physician associations (IPAs); restrictive covenants; and regulatory, employment, tax and litigation matters. **Think of us as preventive medicine for your practice.**

For information please call our Health Care Law Practice Group Co-Chairs: Michael F. Schaff at (732) 855-6047 or Francis V. Bonello at (732) 389-5636.

**WILENTZ
GOLDMAN
& SPITZER**
ATTORNEYS AT LAW

**"Helping The Health
Care Professional"**

Woodbridge, NJ
New York, NY
Eatontown, NJ

<http://www.newjerseylaw.com>

WHO ARE THE UNINSURED?

IN NEW JERSEY, WHEN IT COMES TO CARE AND UPKEEP, WOULD YOU RATHER BE A CAR OR A HUMAN? AMIDST THE DEBATE OVER AUTOMOBILE INSURANCE REFORM, ONE FACT HAS FAILED TO MAKE IT ONTO THE PUBLIC RADAR SCREEN: CAR INSURANCE IS MANDATORY, AS OF 1996, BUT OVER 1.3 MILLION PEOPLE LACK HEALTH INSURANCE.

By Bill Berlin, PhD

Who are the uninsured? In certain respects, the uninsured are an invisible segment of the population, unorganized and under-represented, people who fall between bureaucratic cracks or opt out of the system. "There is much we don't know about the uninsured in New Jersey," says Amy Mansue, chief executive officer of HIP of New Jersey. Nevertheless, we can sketch out a rough group portrait:

Children. Nearly 375,000 children in New Jersey—18.7 percent of youngsters in the state who are 18 and under—lack health insurance. Most of these children come from families with at least one working parent.

The working poor. About 820,000 of New Jersey's 1.3 million uninsured are full-time workers and their families. One out of six of these full-time workers are employed by a company with more than 1,000 employees.

Young adults. In New Jersey, 34.6 percent of the age 19 to 24 population is uninsured, and 23 percent of those age



25 to 34 lack coverage. Some of these are low-income workers. Some are individuals no longer covered by parental plans or college-based insurance and not yet in any permanent job situation. Many are people in very good health who may not see health insurance as a necessity.

The near elderly. People in the 55 to 64 age group who are too young for Medicare are losing health benefits faster than any other age category. The

Employee Benefit Research Institute found that between 1987-1996, Americans ages 55 to 64 without insurance rose 25 percent. The reasons are varied: corporate downsizing; the death of a spouse; or a company's decision to abandon retirement benefits. In 1996, 12.6 percent of this age group in New Jersey lacked insurance. They represent the fastest-growing segment of the American population and are increasingly susceptible to serious illness.

The eligible but uninsured. Estimates vary, but as many as 100,000 New Jerseyans who are eligible for Medicaid may never have signed up.

Historically, these have included low functioning individuals who have "dropped out" of the system, people who were unaware of their eligibility, or people either too embarrassed to apply or reluctant to take time off from work to complete the complicated enrollment process. More recently, confusion over changes in the welfare law have left many individuals with a mistaken belief that they no longer are Medicaid-eligible. The U.S. General Accounting Office estimated that roughly one-third of uninsured children in 1994 qualified for Medicaid but were not enrolled.

Nationally, the ranks of the uninsured have grown steadily in the last decade, from an estimated 31 million in 1987 to 41 million in 1996. A recent survey by Kaiser Family Fund found that 52 million working adults either lacked health insurance or have gone through a period dur-

ing the previous two years without coverage. Another survey, this one conducted by the Centers for Disease Control and Prevention, concluded that 20 percent of Americans between the ages of 18 and 64 either lack health insurance or have inadequate coverage. The survey probably under-reported the number of uninsured Americans since it was based upon interviews with people who had telephones.

We know that people who are uninsured usually go without coverage for more than a year. Men are more likely than women to suffer these gaps in coverage. Blacks are more likely than whites to be uninsured (26.8 percent to 14.7 percent in New Jersey), and Hispanics (at 29.6 percent) are more likely than both groups to go without coverage.

We know, too, that going without insurance is not good for your health. While research shows that the uninsured of any age have less health care and more health problems than those who are covered, the impact on children is most obvious. Uninsured children have fewer immunizations, less preventive care, and are more apt to miss timely treatment of health problems that can lead to hospitalization. The



Amy Mansue, HIP of New Jersey, chief executive officer.

National Health Interviews Survey, the most ambitious national survey of health access ever conducted, found that, on average, children uninsured for one or more years had less than one-half as many doctor visits and inpatient hospital care days than insured youngsters. In any given year, 37 percent of long-term uninsured youngsters do not see a doctor, less than one-half the rate of insured children.

Perhaps most telling, comparisons of insured and uninsured youngsters in fair or poor health show striking differences in access to care. Uninsured children in fair or poor health are four times more likely to have been unable to get needed medical or surgical care, and 4.5 times more likely to have been unable to obtain needed prescription medicines or eyeglasses. Compared to insured youngsters in fair or poor health, the uninsured were five times more likely not to have a usual provider of health care.

Health insurance tends to encourage the use of the health care system from an early age. Con-



Ciro Scalera, executive director of the Association for Children of New Jersey.

versely, those who lack insurance are more likely to receive episodic treatment or none at all. Eric Munoz, MD, medical director at University Hospital in Newark, a facility that treats a large number of uninsured patients, reports that "30 percent of the women who come to the hospital in labor have never seen a health care professional."

How can we account for the relentless growth of the uninsured since the late 1980s, despite increases in Medicaid and other efforts to insure health coverage for the poor? The main reason seems to be the continuing transformation of the workplace and the downscaling of employee benefits.


Between 1990 and 1994, the percentage of the United States population receiving employer-sponsored

health insurance fell by 1 percent a year, from 61 percent to less than 57 percent. The decline in manufacturing jobs, the elimination of semi-skilled workers, and the growing use of part-time and temporary workers have contributed to cutbacks in employee benefits. Moreover, the rapid rise in health care costs in the 1980s encouraged employers to look for ways to reduce or eliminate medical coverage.

Those most hurt by these changes have been low-skill, low-wage workers. Increasingly, differences in access to health insurance seem to be related to disparities in income. Roughly 4 percent more workers earning more than ten dollars an hour in 1996 were offered insurance compared to the same group in 1987. However, for those earning less than seven dollars an hour, access dropped by 12.5 percent during the same period.

The nonpartisan Council on the Economic Impact of Health System Change estimates that, if current trends continue, the uninsured population could reach 67 million in 2002, 24 percent of the entire population. A more modest estimate puts this figure at 50 to 55 million. In either case, the impact would be

profound, especially on major teaching hospitals and inner-city hospitals. Workers covered under private insurance would see a major bump in health care costs and corresponding cuts in real wages.

n the federal level, the failure of the Clinton health plan has led to what some observers have dubbed "Hillary Lite,"

piecemeal, and, thus far, mixed efforts at dealing with problem of the uninsured. The Health Care Portability and Accountability Act, which went into effect on July 1 of last year, sought to ensure that workers who transfer jobs could take their insurance with them. The law, often referred to as Kennedy-Kassebaum, after its prime sponsors, also limits employer-sponsored health plans from excluding people based upon pre-existing conditions. Early reports suggest that the law is not having the desired effect, since it does not regulate the price of new insurance, only the availability.

The landmark Balanced Budget Act of 1997 created the State

Children's Health Insurance Program (SCHIP), which appropriates \$20.3 billion to states over the next five years to expand health care coverage to uninsured, low-income children. In addition, early this year President Clinton suggested extending Medicare eligibility to people in the vulnerable 55 to 64 age group, the proposal that is unlikely to pass the current Congress.

In New Jersey, the Whitman administration has followed up on SCHIP by enacting legislation that would extend health insurance coverage to roughly 40 percent of uninsured children—102,000 youngsters. The new program, New Jersey KidCare, allocates \$136 million in federal and state funds for children from families that do not qualify for welfare or Medicaid but who cannot afford private insurance. New Jersey KidCare will offer benefits akin to

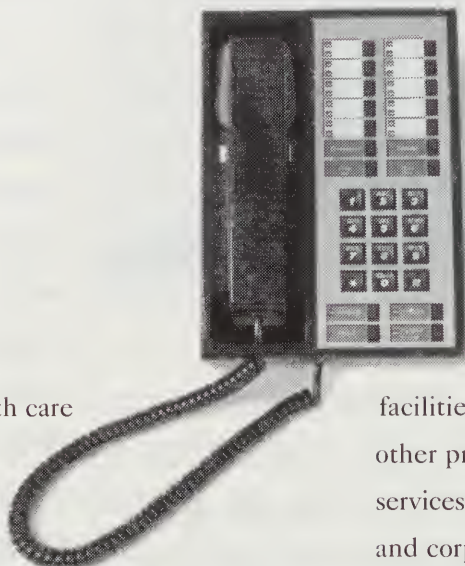
those provided by employer-sponsored HMOs, including regular checkups, immunizations, and hospitalization.

The state also has created a unique program providing two years of transitional medical coverage for people who no longer are on welfare and now are working. Together with earlier reforms that make it easier for small businesses to offer medical insurance, these programs, some observers believe, put New Jersey in the front rank of states dealing with the uninsured issue. "I definitely think New Jersey is doing a better job for uninsured kids," says Ciro Scalera, executive director of the Association for Children of New Jersey, "because we learned from the mistakes of other states."

Still, Scalera and other advocates for the uninsured believe that employment trends, rising health care costs, and an inevitable economic downturn will continue to swell the ranks of the uninsured. Unless we opt for more sweeping reforms, he says, we are "treading water" on the issue. Less compelling than automobile insurance reform but equally persistent, the problem of the medically uninsured may be with us for some time to come.

HOW CAN NEW JERSEY ACCOUNT FOR THE GROWTH OF THE UNINSURED SINCE THE LATE 1980S?

When professional health law counsel is called for,
call the firm the experts are calling.



For years health care providers and businesses have been calling Theodosia A. Tamborlane P.C. when they needed accurate information, insightful commentary and practical advice. That's because Theodosia A. Tamborlane P.C. successfully navigates through the maze of government activity at both state and federal levels every day.

Today physicians, hospitals, nursing homes, assisted living, ambulatory care

facilities, home health care agencies and other providers turn to this firm for legal services including managed care contracting and corporate compliance plans. It's little wonder why leading health law publications and the nation's most prestigious legal, medical and business associations keep calling Theodosia A. Tamborlane P.C. to keep their members up to date. When you need professional legal counsel select the firm that knows the issues ...

Theodosia A. Tamborlane, P.C.



THEODOSIA A. TAMBORLANE, P.C.

COUNSELORS AT LAW

1044 ROUTE 22 WEST, MOUNTAINSIDE, NEW JERSEY 07092

908-789-7977

Member, American Medical Association Doctors Advisory Network

Charter Member, American Association of Physician-Hospital Organizations-Integrated Healthcare Delivery Systems

TOURETTE Sights and Sounds

FROM MILD EYE-BLINKING TO INTENSE LEG AND ARM JERKING. FROM IMITATION TO OFFENSIVE LANGUAGE. THESE ARE THE MOTOR AND VERBAL TICS OF PATIENTS SUFFERING FROM TOURETTE SYNDROME. AND, WHILE PHYSICIANS STRUGGLE TO UNDERSTAND THE DISEASE, THE INSURANCE INDUSTRY IS CATEGORIZING THE SYNDROME.

By Suzanne Barlyn

Tourette syndrome (TS) rarely strikes with the sensationalism that often is the subject of media attention. The cruelty of this neurobiological disorder is a changing pattern of physical and behavioral manifestations that begins in childhood and frequently can evade diagnosis for years.

"It's parenting in the trenches," says one New Jersey mother, whose son's repeated crotch-touching at age four marked the onset of TS. His constant throat clearing irritates her, a common parental response to the vocal and motor tics that impact TS sufferers and their families.

After being diagnosed at age ten, the boy joined an estimated 100,000 Americans who suffer from the full-blown disorder. His symptoms included attention deficit disorder (ADD), one of several hyperactivity and learning disorders that affect about 50 percent of TS sufferers,



Physical and vocal tics are closely intertwined with Tourette syndrome.

© Mark Bechelman

according to the Tourette Syndrome Association, Inc. (TSA) in Bayside, New York. TSA estimates that one-third of patients exhibit obsessive traits; depression and sleep disorders also are common.

There is no diagnostic test for TS, named after Dr. Georges Gilles de la Tourette, a French neurologist who described the condition in 1885. The disorder is inherited as a dominant gene believed to cause a chemical imbalance involving dopamine and, possibly, other neurotransmitters in the brain.

TS is unlike transient childhood tic disorders, which dissipate within weeks to months. TS is characterized by frequently changing motor and vocal tics present for more than a year. Since the symptoms wax and wane, the condition may not be immediately visible to physicians.

"There's no question that patients have an awareness of these tics in certain situations, such as coming into a doctor's office. They will try to control the tics so that they won't embarrass themselves socially," says MSNJ member Dorothy Pietrucha, MD, director of pediatric neurology at the Department of Pediatrics at Jersey Shore Medical Center in Neptune.

Fortunately, the gap between onset and clinical diagnosis is narrowing. TSA, which conducts ongoing education programs, reports that some patients are diagnosed within six months to a year, according to Sue Levi-Pearl, director of

medical and scientific programs for TSA. Symptoms often abate during adulthood. Many patients lead productive lives, even while symptoms are present.

While awareness is increasing, many physicians and health insurance companies disagree over how to classify the disorder. Dennis Deutsch, legal counsel for the Tourette Syndrome Association of New Jersey, Inc. (TSANJ) was involved in the controversy five years ago when, he notes, many insurance providers designated TS a psychiatric disorder, resulting in reimbursements as low as 50 percent for some patients.

Deutsch says the threat of litigation combined with evidence of the disorder's neurological characteristics convinced some carriers to classify TS as a physical condition and reimburse patients at the 80 percent level.

Today, physicians report similar challenges. "Some insurance companies treat it as a psychiatric disorder," says Trevor DeSouza, MD, a pediatric neurologist in Madison and MSNJ member. "But if you look at the actual physiology, the reason why the drugs work is because they're working at the level of neurotransmitters in the brain."

**TOURETTE SYNDROME
CAUSES A CHEMICAL
IMBALANCE INVOLVING
DOPAMINE AND OTHER
NEUROTRANSMITTERS
IN THE BRAIN.**

As the number of managed care networks surge, patients also are concerned about access to physicians. A 41-year-old woman said she pays for some treatments out of pocket because there are no specialists in her network. "Patients with TS are experiencing this inability to see specialists more and more," suggests Levi-Pearl.

Expertise is critical since TS is incurable. Managing the most severe cases requires proficiency with a spectrum of drugs and their side effects. About 30 to 40 percent of TS patients are treated with medication, according to DeSouza. "I don't initiate drug therapy unless I'm dealing with very severe tics and they're affecting psychosocial relationships and interpersonal functioning," he notes.

In cases requiring treatment, a physician must first assess an understanding of TS medications. "A lot of the management is based on the expertise of physicians with these medications in terms of titrating the dose and watching for possible side effects," says Pietrucha.

Neuroleptics such as haloperidol and pimozide are prescribed to relieve motor and vocal tics that hinder daily functioning. Side effects, which DeSouza finds are more prevalent with haloperidol, include sedation and weight gain, and in rare cases, tardive dyskinesia, an involuntary movement disorder.

Clonidine, an anti-hypertensive, and clonazepam, an anti-convulsant, also treat tics. Risperidone, an anti-psychotic, is emerging as a therapy for TS patients who have responded poorly to other drugs.

Management is more difficult when tics are accompanied by obses-

sive traits or a hyperactivity disorder. Although neurostimulants such as methylphenidate and dextroamphetamine effectively control ADD and attention deficit hyperactivity disorder (ADHD), they also may exacerbate tics.

The physician then must determine which symptoms are most troublesome. "None of the drugs really affects all three layers of TS," explains David E. Mandelbaum, director of the division of child neurology at UMDNJ-Robert Wood Johnson Medical School in New Brunswick. "You often are confronted with a situation where you have to ask the person: 'What's bothering you the most? I don't want to put you on three different drugs.'"

No drug can treat every symptom, yet guanfacine, an anti-hypertensive, and clonidine may be effective in managing both hyperactivity disorders and tics, says Mandelbaum.

Selective serotonin reuptake inhibitors such as fluoxetine, paroxetine, clomipramine, and sertraline, are common defenses against obsessive disorders and depression. Since they are ineffective in tic management, a combination of drugs may be administered.

In the absence of medication, Pietrucha recommends behavior modification techniques. Since patients often express an absolute

MANAGEMENT OF TOURETTE
SYNDROME IS BASED ON
PHYSICIAN EXPERTISE,
WITH MEDICATION AND
THEIR KNOWLEDGE OF
SIDE EFFECTS.

need to tic, she advises them to control the impulse in situations that may heighten self-consciousness, and then tic in an unrestrained manner at home. Chewing gum may help to control facial motor tics while squeezing a small ball may relieve tics involving the arms and hands.

"Being made fun of can sometimes be the worst symptom in the world," says Mandelbaum. "I'd like to treat everyone else by generating some understanding of the problem to avoid giving a potent pharmacological agent to a child."

The broad spectrum of symptoms of TS was evident during a recent support group meeting for adults sponsored by TSANJ. Although a few of the 17 patients exhibited the severe physical and vocal tics that are closely intertwined with the disorder, many of the attendee's symptoms were barely perceptible to an untrained eye.

Group members were united by similar concerns, despite their varying levels of affliction. Most of the members, ages 23 to 52, contended with the frustrations of pharmaco-

logical treatment and its side-effects. Several people reported relief from drug therapy, while a few abandoned medication entirely. A small minority of patients had never been medicated.

A 37-year-old woman said she was plagued by tics during childhood. "I went through a phase where I thought I was retarded or adopted," she said. "I couldn't understand why I had urges to jerk my arms and kick my feet while I didn't see any other children doing these things."

Patients' motor tics ranged from mild eye-blinking to intense leg and arm jerking. Only a few patients exhibited vocal tics, including echolalia, a tendency to imitate what they had just heard. No one exhibited coprolalia, a propensity to utter foul and offensive language. The condition is the most widely stereotyped TS symptom, yet it affects between 5 and 30 percent of patients.

The meetings offer patients a refuge from an outside environment that is often unaccepting of their physical problems. As one woman said, "I feel uncomfortable because I know I make noises and people think I'm weird."

TSANJ, a Somerville-based organization of 1,400 families and professionals, sponsors six support groups throughout the state for TS sufferers and their families. For more information about TSANJ's support groups, help line, and school in-service programs, call 732.972.4459 or visit TSANJ's web site at www.tsanj.org.

Medical Society of New Jersey

Long Term Care Insurance Program

Ensuring a Secure Future by Preserving Assets

As medical professionals, you know first hand the devastating effects that extended long term care can have on a person's hard earned assets. The cost of nursing home stays can range from \$3,000-\$5,000 per month. The Medical Society of New Jersey endorses The Travelers and CNA Insurance Companies' policies to help you guard against unforeseen tragedies. Through a special arrangement with The Travelers and CNA Insurance Companies, members, spouses, parents and in-laws are eligible for a premium reduction.

IMPORTANT FEATURES OF THE MSNJ ENDORSED LONG TERM CARE INSURANCE PROGRAM

- ◆ Available Ages 45-84
- ◆ Specialty Plans Available Ages 80-100
- ◆ Benefits up to \$250/day
- ◆ No prior hospitalization required
- ◆ Several waiting periods
- ◆ Alzheimer's, senility covered
- ◆ Lifetime benefits available
- ◆ Guaranteed renewable for life
- ◆ Coverage for custodial, skilled and intermediate care as well as adult day care
- ◆ Available to your spouse, parents and in-laws
- ◆ Waiver of premium benefit
- ◆ Inflation protection available

DISCOUNT FOR MEMBERS OF MSNJ, SPOUSES, PARENTS AND IN-LAWS

For more information, please call

DONALD F. SMITH & ASSOCIATES

A division of THE COPELAND COMPANIES[®]

Two Tower Center, P.O. Box 1063
East Brunswick, New Jersey 08816-1063

(888) 297-7225

Copeland Associates, Inc.

Medical Society of New Jersey
MSNJ

PATTERNS OF CARE

STAGE I CARCINOMA OF THE ENDOMETRIUM

ENDOMETRIAL CANCER IS THE FOURTH MOST COMMON CANCER IN FEMALES. RISK FACTORS INCLUDE UNOPPOSED ESTROGEN USE, LOW PARITY, EARLY MENARCHE, LATE MENOPAUSE, MORBID OBESITY, LONG-TERM TAMOXIFEN USE, HYPERTENSION, DIABETES MELLITUS, AND POLYCYSTIC OVARIAN DISEASE.

By Joseph W. Fanelle, MD

Endometrial cancers are the most common gynecological malignancy in the United States. With over 31,000 cases reported in 1994, 5,900 women died of this disease that year.¹ Currently, endometrial cancer is the fourth most common cancer in females, ranking behind lung, breast, and bowel.² The

relatively high survival rate demonstrates that the disease usually is diagnosed in its early stages. Approximately 75 percent of cases occurs in postmenopausal females, and less than 5 percent occurs in women

Dr. Fanelle at work at South Jersey Hospital.



less than 40 years of age. Risk factors include unopposed estrogen, chronic prolonged estrogen use, low parity, early menarche, late menopause, morbid obesity, long-term tamoxifen use, hypertension, diabetes mellitus, and polycystic ovarian disease.³

The South Jersey Regional Cancer Center (SJRCC) is approved by the American College of Surgeons Commission on Cancer as a community hospital compre-

hensive cancer program. The Tumor Registry at SJRCC has been accessioning information on carcinoma of the endometrium since January 1, 1982, and was queried for all analytical Stage I cancers of the endometrium treated from January 1, 1982, through June 30, 1995. The distribution by stage of cases accessioned at South Jersey Hospital (SJH) is similar to the other published databases as a majority (almost 75 percent) of cases are diagnosed as Stage I. A total of 127 evaluable charts was reviewed and the following prognostic factors were identified: age, stage, race, histology,

grade, depth of myometrial invasion, type of surgery, use of radiation, followup interval, disease status, and history of secondary malignancies. All patients in the current series were restaged using the 1988 Federation International de Gynecologie et d'Obstetique staging system. The SJH cohort was analyzed in June 1997, to allow for a minimum of two-year followup interval. Median followup interval of the entire cohort is 61.5 months with a range of 0 to 175 months. All patients were followed until death or counted in statistics until the last known date of followup.

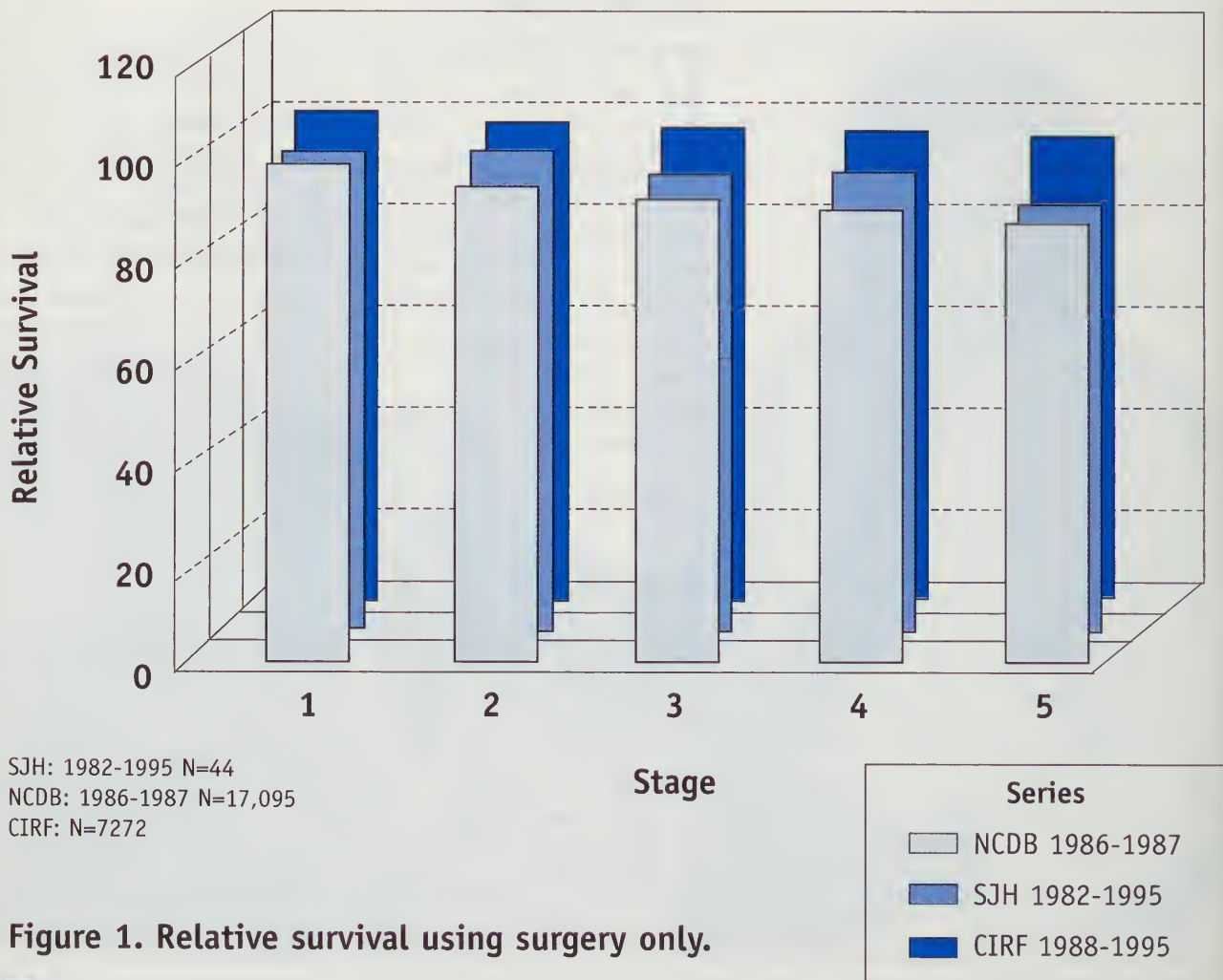


Figure 1. Relative survival using surgery only.

Histologic-
ally, 109
cases were
identified as
being adeno-
carcinomas
while 17 were
identified as
being ade-
noacanthomas. One case was
reported as a papillary serous carci-
noma. There were no adenosqua-
mous or clear cell carcinomas
reported. This is most likely due to
the sampling number during patho-
logical review of a hysterectomy
specimen.⁴ Sixty-nine cases were
identified as being Grade I, 40 were

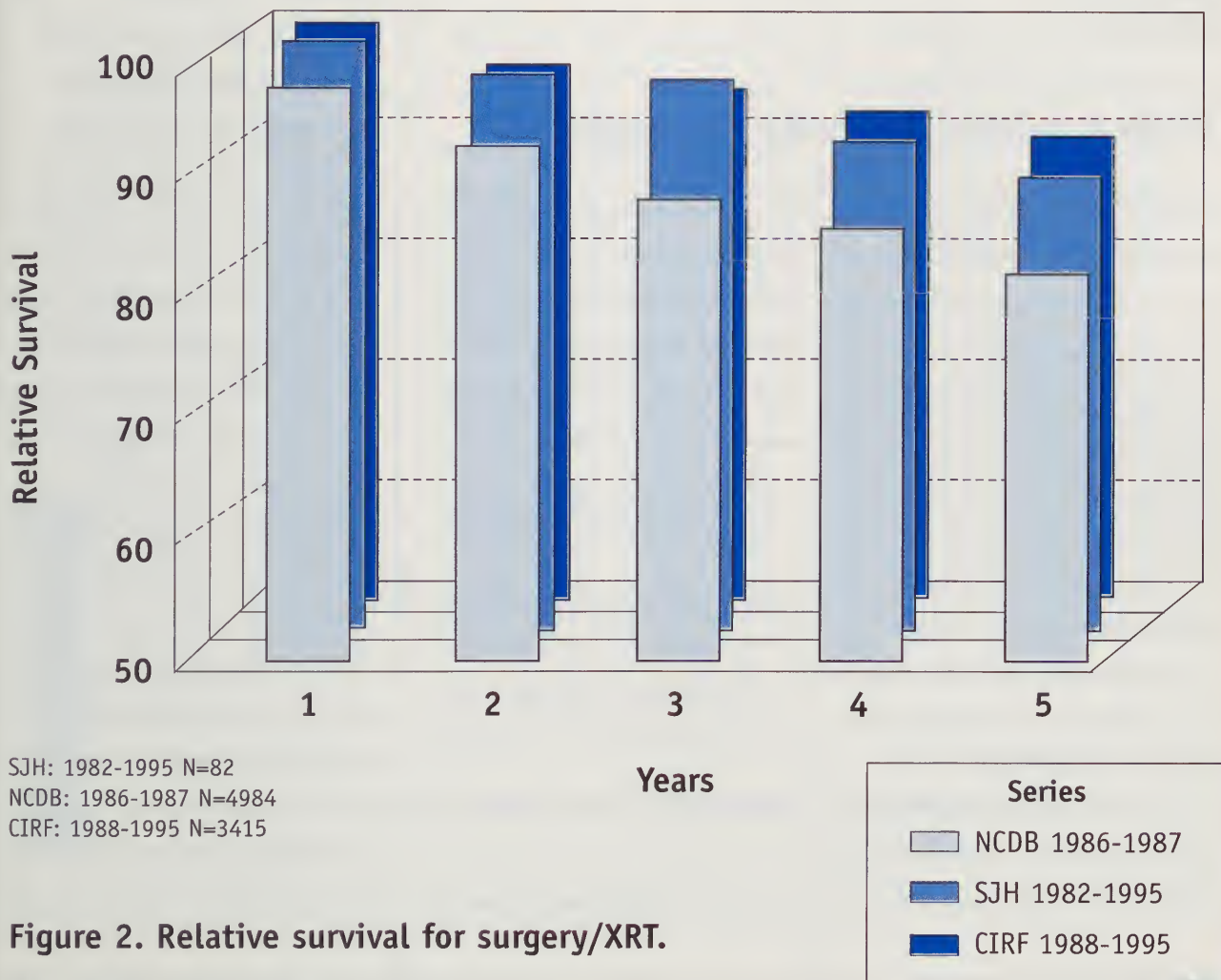
**SEVENTY-FIVE PERCENT OF
PATIENTS UNDERWENT
SOME TYPE OF
HYSTERECTOMY WITH
POSTOPERATIVE EXTERNAL
BEAM THERAPY.**

Grade II, and 15 were Grade III.
There were two cases identified as
Grade IV. The one ungraded speci-
men was identified as a papillary
serous carcinoma.

Age range of the cohort was
between 31 and 86 with a median age

of 67, which is comparable to
National Cancer Institute (NCI)
and National Cancer Database
(NCDB) data. A majority of the
patients (93 percent) identified
themselves as Caucasian while 6.3
percent identified themselves as
African-American; one patient
identified herself as Asian-Pacific.
The higher Caucasian rate in the
SJRCC cohort is due to the fact that
race was identified in all SJH
patients while the NCDB reported a
significant proportion of unknown
race.

There was a total of 15 secondary
tumors (15/127) identified in 14



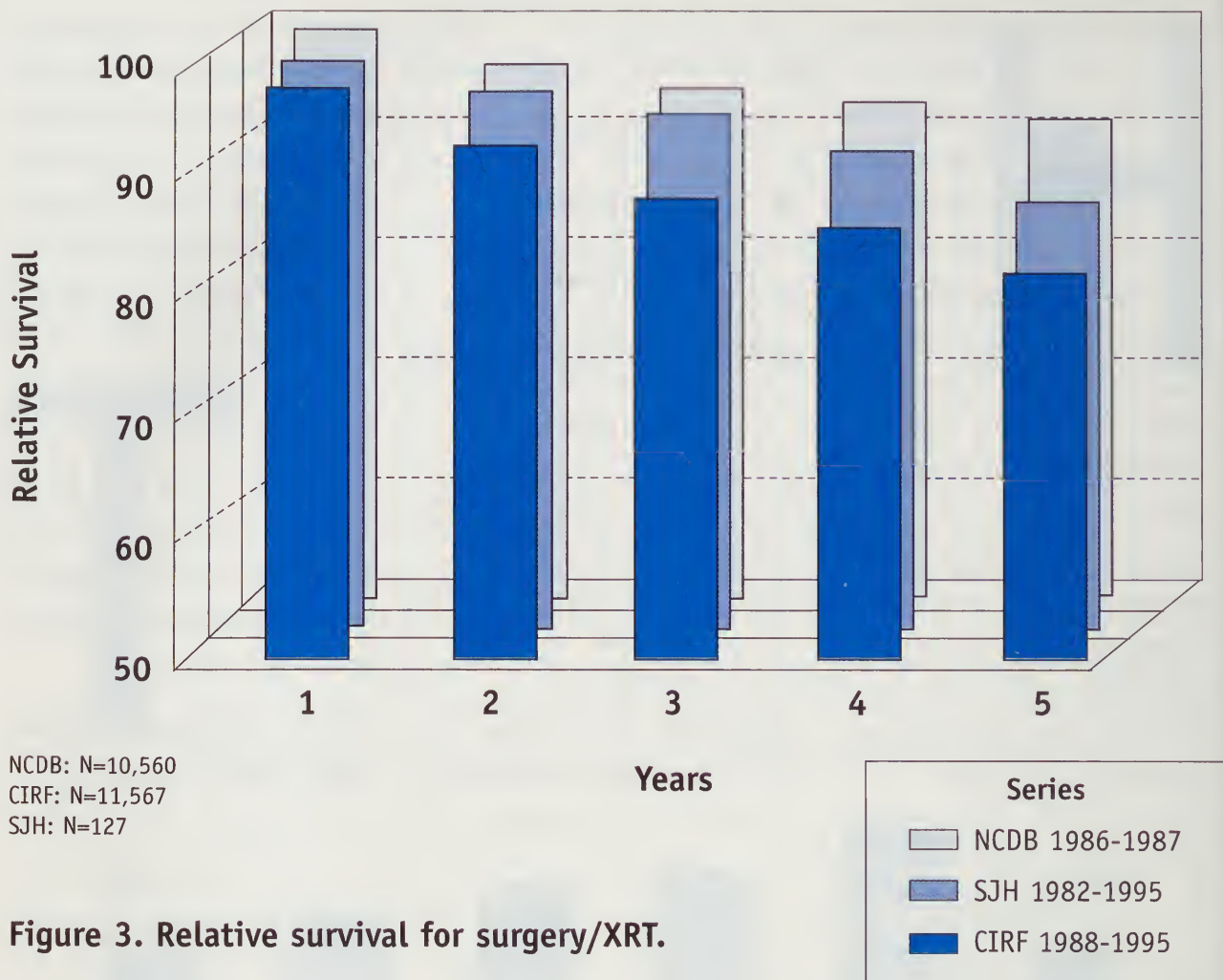


Figure 3. Relative survival for surgery/XRT.

patients, representing an overall crude rate of 11.8 percent. Most of these tumors appear to be other types of adenocarcinomas, although two squamous cell carcinomas (vagina and skin) also were noted. Eight of these tumors were metachronous while seven of the tumors were synchronous. All synchronous tumors were breast or ovarian in origin. The family histories of these patients were incomplete so detailed analysis could not be performed.

Patients in the SJH cohort underwent three combinations of therapy: surgery only, surgery and radiation,

or radiation only. Seventy-five patients underwent some type of hysterectomy followed by postoperative external beam therapy, with or without an intracavitary boost. Seven

patients underwent preoperative radiotherapy followed by an extrafascial hysterectomy. Forty-four patients underwent hysterectomy only. One patient received definitive radiation only. Postoperative radiation most likely was recommended after deep myometrial involvement was noted. Patients referred for postoperative radiation were sent from other institutions, which explains why the SJH cohort has a reversed ratio (surgery only versus surgery and postoperative external beam radiation) when compared to other series.

THE TUMOR REGISTRY
DATABASE IS A VALUABLE
TOOL FOR ANALYZING
RETROSPECTIVE OUTCOME
DATA FOR NEW JERSEY.

The recommendation for postoperative radiation usually is made based on risk factors found after pathologic review of the hysterectomy specimen. As would be expected, very few patients receive postoperative radiation if they had inner third myometrial invasion and/or well-differentiated tumors. The majority of patients who had outer third myometrial invasion or high-grade tumors received adjuvant postoperative radiation. Relative survival by depth of myometrial invasion shows that patients who have superficial myometrial invasion had the best survival. Patients with middle and outer myometrial invasion had similar survival, which may be due to the addition of postoperative XRT. This, however, has never been clearly demonstrated in a large, randomized clinical trial.

In order to meaningfully compare outcome statistics, the two database references were used: the NCDB and the Cancer Information Reference Files (CIRF). CIRF data represent patients diagnosed and treated between 1988 and

POSTOPERATIVE RADIATION IS SUGGESTED AFTER PATHOLOGIC REVIEW OF THE HYSTERECTOMY SPECIMEN.

1995. The NCDB supplied data from study years 1986-1987 and 1992.

Relative survival of surgery alone for the SJH cohort is compared to the NCDB 1986-1987 and a CIRF 1988-1995 cohort(s) (Figure 1). The relative survival for combined modality (grouping both preoperative and postoperative regimens together) also was compared to NCDB and CIRF cohorts (Figure 2). The relative survival of all stage I endometrial cases is compared with the same large national databases (Figure 3). The SJH cohort appears to have equivalent relative survival regardless of the treatment modality.

The SJH Tumor Registry database is a valuable tool in analyzing retrospective outcome data. Individual

patient characteristics, treatment, and outcome parameters can be analyzed to explain common and unique patterns of care management at SJH. Patients treated for stage I cancer of the endometrium have comparable treatment and relative overall survival when compared to several national databases.

REFERENCES

1. NCDB Annual Review of Patient Care, 48-65, 1995.
2. Hoskins P: *Principles and Practices of Gynecological Oncology*. Philadelphia, PA, J.P. Lippincott Company, 1992.
3. Piver S: *Handbook of Gynecological Oncology*. Boston, MA, Little, Brown & Co., 1995.
4. Christopherson W: Carcinoma of the endometrium II papillary adenocarcinoma: A clinical pathological study, 46 patients. *Am J Clin Pathol* 77:534-540, 1982.
5. Medical Registry Services, 1 University Plaza, Hackensack, NJ.

Dr. Fanelle is clinical director, Department of Radiation Oncology, South Jersey Hospital, and medical director, South Jersey Regional Cancer Center, Millville.

Our medical specialists make a practice of creating solutions for physicians like you.

Summit Bank's Healthcare Financial Services Group features some of the finest medical specialists in New Jersey. They understand your industry and the issues facing it. As New Jersey's largest locally headquartered bank, our professionals are specifically devoted to the healthcare industry. That means our customized solutions — from loans to leases — come with something extra: time-tested expertise. If you'd like, we'll even help you find a more efficient way to run your practice. To find out more, call Norm Buttaci, Regional Vice President, 609-987-3561.



Summit, Summit Bancorp and Reach Higher are registered service marks of Summit Bancorp • Summit Bank is a service mark of Summit Bancorp.

ROBERT L. PICKENS

The New Jersey Medicine Interview

WITH FUNDING SUPPORT FROM THE ROBERT WOOD JOHNSON FOUNDATION, MSNJ CONVENED THE NEW JERSEY COMMISSION ON THE PHYSICIAN WORKFORCE. ITS CHARGE IS TO CREATE A FRAMEWORK FOR A COMPREHENSIVE, REALISTIC APPROACH TO PHYSICIAN WORKFORCE ISSUES. THE NEW JERSEY GROUP WANTS TO UNDERSTAND THE WAYS TO HELP MAXIMIZE PRODUCTIVITY, QUALITY, FAIRNESS, PROFESSIONAL OPPORTUNITIES, AND ACCESS IN HEALTH CARE.

By Bill Berlin, PhD

Q. What is the genesis of the New Jersey Commission on the Physician Workforce?

A. The Commission grew out of conversations with The Robert Wood Johnson Foundation and the feeling that existing forums in the state had not yielded an effective approach to physician workforce issues, graduate medical education funding, specialty surplus, the large IMG population in New Jersey, and issues of access and distribution.

The Robert Wood Johnson Foundation has devoted more than

\$500 million to studying physician workforce issues over the last 20 years. Many of the issues have stayed the same during this period, but the forces driving them, particularly on the economic side, have changed. Our goal is to establish a forum that includes new players. The academic medical institutions have controlled the standards and dominated this conversation in the past. For this Commission, we invited 20 stakeholders to the table, representing a range of economic and social interests, including business, labor, and medical ethics.

Q. Might not somebody say, however, that the Commission, under the aegis of the Medical Society of New Jersey (MSNJ), is self-serving?

A. I believe MSNJ often has been deterred from taking a proactive stance precisely because of that question. I think we need to push through that issue. I am pleased to see how much more proactive MSNJ has become on this and other areas. For this reason, we have included many stakeholders, and I think people will see that we don't have an agenda, nor do we have an axe to grind.

Q. Let me turn the question around. How do you respond to a physician who asks, "What does this Commission mean for me? Are we just going to hear more about downsizing?"

A. There has been a lot of talk about downsizing on the national level from such sources as the Pew Commission. Downsizing might be

In the Spotlight

one part of it, but we have expanded the scope to include other issues, such as fair distribution and access, and the role of nurse practitioners and physicians' assistants. As the population changes and shifts in the state, as certain segments of the population grow and others decline, where will we need physicians and health care resources? One of the issues that might come up is the retraining of older physicians to deal with the need for more primary care practitioners.

Q. You are going to be addressing important questions. In terms of the structure and operations of the Commission, how can you do the best possible job?

A. First of all, we have tried to make this as multidisciplinary as possible, with various stakeholders making suggestions for topics and speakers. We are seeking input from experts on several issues—IMGs, graduate medical education funding, the recruitment of minority physicians, and the distribution of physicians. We also are open to suggestions from people outside the Commission. For example, any member of MSNJ who has an idea should reach out to the Commission. Although the Commission was originally designed as a one-year undertaking, one of the questions on the table is whether or



Robert L. Pickens, MD

not to make this an ongoing enterprise.

Q. What do you see as the result of this process, statements of broad principle or recommendations for legislation?

A. It is going to be a combination of both. There are certain things that cut across all interests. Even today, we probably could make certain specific recommendations regarding a dedicated, broad-based support system for graduate medical education. Almost everyone seems to agree on the need for an all-payer system. In other situations where it's not quite as clear, there may be suggestions for further study or broad comments about directions we may want to pursue.

Q. You mentioned the IMG issue. Is this particularly important in New Jersey?

A. A recent edition of *AMA* said that as of July 1, IMGs seeking to enter American residency programs must pass a clinical skills assessment exam, which supposedly will measure clinical and interpersonal abilities, including writing and communication skills. The test will cost \$1,200 to take and will only be offered in Philadelphia. The exam may be extended to graduates of American medical schools in the future. That is interesting, and certainly in a state like New Jersey, which is dependent on physicians trained abroad, it will raise important questions.

Q. What other factors are particular to New Jersey?

A. We have to take into account the state's large and growing retired population, our large inner-city population, the projected growth of our foreign-born and non-white populations, and the AIDS problem in the state. Unfortunately, New Jersey leads other highly industrialized states in the range of health-related issues, such as the number of urban children who lack complete vaccinations.

Q. Looking into the future always involves some risk. Will you take into account the possibility of

diseases, such as AIDS, or the spread of diseases that may be resistant to antibiotics?

A. That's hard to say, but just the fact that you or I may make that observation is important. In the past, we were naïve and parochial to think that once we conquered cancer, we'd be home free. I think we're more sophisticated today and have a better understanding that there always will be another challenge. There are certain things we know. For example, the projected growth in the over-65 age population means that we will need primary care physicians and geriatricians, no matter what else the future holds. There will be unknowns, but we will have to be able to deal with them.

Q. You have been very concerned about ethical issues in medicine. Will those issues inform the process?

A. No question about it. I have worked closely with Rick Sinding of New Jersey HEALTHDECISIONS, and I am a member of this Commission. Ethical, rather than economic, considerations should drive our discussions. It has been a constant battle with the HMO influence to make sure that economic considerations do not prevail. This is

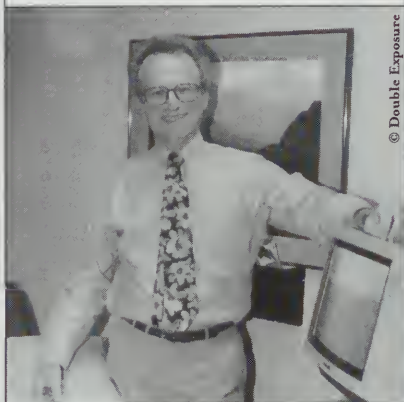
something with which we must contend. Equal access to health care and the needs of the uninsured are important principles that will influence our discussions.

Q. What is your hope or vision for the Commission?

A. My hope is that at the end of this process we will have a comprehensive, realistic approach to workforce issues that will enable us to maximize productivity, fairness, and equal access, and will respect the rights of both physicians and patients in this dialogue. ■

Chair of the New Jersey Commission on the Physician Workforce, Robert L. Pickens, MD, is in private practice in Princeton. A urologist, Dr. Pickens is affiliated with The Medical Center at Princeton and UMDNJ-Robert Wood Johnson Medical School. A member of MSNJ and of the AMA, he also is a member of the MSNJ Committee on Biomedical Ethics.

A realistic approach to workforce issues is Pickens' goal for the Commission.



© Double Exposure

New Jersey Commission on the Physician Workforce

Robert L. Pickens, MD, Chair
Martin J. Scott, DO, Vice-Chair

Members

Sofia H. Anthony, MD,
The Academy of Medicine of NJ
Andrea Aughenbaugh, RN,
NJ State Nurses Association
William Black, MD, NJ Advisory Graduate
Medical Education Council
Marilyn Dahl, Office Policy & Research
Kenneth W. Faistl, MD, NJ Academy of
Family Physicians
William V. Harrer, MD, NJ Board
of Medical Examiners
Frederick J. Humphrey, II, DO,
UMDNJ-School of Osteopathic Medicine
Paul Langevin, NJ Association
of Health Plans
Ruy V. Lourenco, MD, UMDNJ-New Jersey
Medical School
Bryan Markowitz, NJ Business and
Industry Association
Joan C. Neuwirth, AARP Health Advocacy
Services
Lynn B. Nicholas, New Jersey Hospital
Association
Sindy Paul, MD, NJ Department of Health
and Senior Services
Harold Paz, MD, MS, UMDNJ-Robert Wood
Johnson Medical School
Carlo Porcaro, MD, International Medical
Graduates Section, MSNJ
Dennis P. Quinlan, MD, The Advisory GME
Council of NJ
Carl Restivo, Jr, MD, MSNJ
Edmund O. Rothschild, MD, St. Joseph's
Hospital and Medical Center
Lynn Schwenger, UMDNJ-Robert Wood
Johnson Medical School
Eleanor H. Seel, Office of Legislative
Services
Richard V. Sinding, New Jersey
HEALTHDECISIONS
Bernardo Toro-Echague, MD, MSNJ
Lucille Wallington, MPH, NJ Primary Care
Association
Susan Walsh, MD, Plainfield Health Center
Neil E. Weisfeld, MSNJ
Mary Willis, NJ Carpenters Funds



Know anybody like our little cartoon friend here? You might know someone with Tourette Syndrome – a neurological disorder that's often misdiagnosed and misunderstood – and a lot more common than you think.



Just like a lot of human beings with TS he often tics, twitches, shouts, blurts out strange and (very rarely) offensive words, and exhibits a lot of odd behaviors that even our scientific researchers don't fully understand yet. But we are making progress.



Individuals with Tourette Syndrome need your understanding and support until the day comes soon when we might control its effects, find better treatments and even find a cure.



Until then, if you know someone who acts like our little friend here, it just might be Tourette Syndrome. And to do that someone a favor you might wish to call the Tourette Syndrome Association of New Jersey, Inc. for help or a free information packet.



Tourette Syndrome Association of New Jersey, Inc

PO Box 1251 / Marlton, NJ 08053 / 732 972 4459 / e-mail us at: njtsa@aol.com

SELF

Clearing the way for

HELP

KEEPING PATIENTS NO LONGER IS ALL THAT NEEDS TO BE DONE TO HELP ENSURE RECOVERY. SELF-HELP GROUPS CAN BE AS IMPORTANT TO THE QUALITY OF A PATIENT'S LIFE AS A PRESCRIPTION. SELF-HELP GOT OFF THE GROUND IN NEW JERSEY WITH THE CLEARINGHOUSE, WHICH OFFERS SERVICES STATEWIDE.

By *Penelope Prosperi, LCSW; Michael Alpert MD, MPH*



Social support networks help healthy people stay healthy, quicken recovery, and improve the quality of life for those with chronic illnesses. C. Everett Koop, MD, former U.S. surgeon general, said, "I learned how to diagnose and treat patients with a variety of disease conditions. What we wanted to do was cure people, repair their hurt and broken bodies, and sometimes their broken minds. Today, that desire alone is not a sufficient basis for a health care system. Mending people, curing them, is no longer enough. It is only part of the total health care that most people require."

Support systems are available through the Self-Help Clearinghouse.

Advising a patient of a self-help group can be as important to the quality of a patient's life as a prescription for erythromycin, non-steroidals, or calcium channel blockers.

A support group referral is not an alternative to professional services, rather it acts as an adjunct. Kathleen Gaioni, MD, states, "It never has been enough to diagnose and medicate. Not even enough to educate and comfort. I have always wanted to provide a more durable support for my patients, especially those coping with exceedingly stressful medical problems."

Self-help groups offer patients and families emotional support and practical information, and help to reduce isolation and fear about medical conditions. Meeting with peers and those who have learned to cope with illness has a normalizing effect on those with any isolating illness or disability; it offers a relief that even the most sympathetic physician cannot extend.

A survey conducted by Harvard researchers found that 18.1 percent of the American population has

participated in a member-run self-help group at some time in their life, and 6.9 percent has done so in the last year. The study notes that those who reported having less supportive social networks were more likely to attend a self-help group than those with more supportive networks.

The popularization of the world wide web has led to computer online self-help groups. With a computer, modem, and online access, a patient can participate in over 1,000 support group meetings from home, office, or public library. Online computer systems are removing many of the barriers that previously prevented people from attending a self-help group. These barriers ranged from the lack of groups in more rural areas, a lack of time due to caregiver responsibilities, a lack

of transportation, and the rarity of an illness or condition, to the incapacities imposed by severe physical disabilities. Examples of such online support networks are those for people with agoraphobia, so severe they could not initially leave home, and those for the scattered men across the country with breast cancer.

As the number of groups, both face-to-face and online, increases, physicians and potential group members have sought reliable sources of information about support group meetings. One of the objectives of Healthy People 2000: National Health Promotion and Disease Prevention called for the establishment of self-help clearinghouses in 25 states because of the unique ability to improve physical and mental health by providing such information. The first state clearinghouse was the New Jersey Self-Help Clearinghouse. Located at Northwest Covenant Medical Center, in Denville, the Clearinghouse provides information, support, and training services for persons interested in finding or forming self-help support groups throughout the state via its toll-free telephone number (1.800.367.6274). As the first computerized operation of its type,

The New Jersey Self-Help Clearinghouse offers telephone support and referrals.



the Clearinghouse maintains and continually updates a database on over 4,000 support group meetings in New Jersey, over 800 national/model groups, and over 200 helplines and hotlines.

Approximately 16,000 people call the Clearinghouse every year seeking information about a group meeting in their area. Of these 16,000 callers, approximately 25 percent are professionals

A SUPPORT GROUP
REFERRAL IS NOT AN
ALTERNATIVE TO
PROFESSIONAL
MEDICAL SERVICES.

seeking a support group for a patient.

Groups exist for those suffering with stroke, narcolepsy, and liver disease, for epilepsy and chronic mental illnesses, and for neurofibromatosis and heart disease, as well

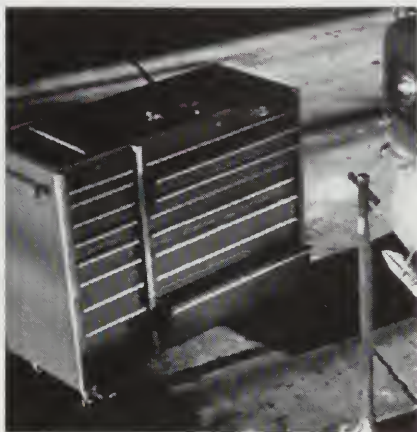
as for caretakers such as those caring for aging parents or a child with a disability. A searchable database of national support groups is available on the Clearinghouse's web site: <http://www.cmhc.com/selfhelp>.

Some people do not benefit from participation at the first support group meeting they attend. Some groups are very structured, adopting specific steps or methodologies; other groups are less structured. Others, such as substance abuse recovery groups, may be experienced as being too spiritually focused for some patients who may feel more comfortable at one of the more recently established groups that has a less structured program with no "higher power" approach. Sometimes the degree to which group members are disabled frightens new, less seriously ill patients. In suggesting a group, physicians may want to suggest several different groups and the patient then can decide which group is most appropriate. By telling them in advance, "Groups vary, just as physicians do. It's important to take time to find a group right for you," physicians prepare patients for the process of finding a group that will meet their need for support and information.

Help Yourself

- TOUCH, a self-help group for cancer patients in Alabama, focused on teaching its members about cancer and training them to be peer counselors to help other patients. The longer members participated in a group, the more their knowledge of cancer improved along with their ability to talk with others.
- David Spiegel, MD, of Stanford University, noted that the survival rate of women with breast cancer in a professionally run support group, where one of the professional facilitators had breast cancer, was double that of the control group that did not receive such support.
- Results of a University of Chicago Medical School study of older men with diabetes found that those who learned self-care techniques and participated in support groups are less depressed and less stressed, and rate the quality of their lives higher than those who didn't take such actions.

Only MIIX offers



the Toolkit that fits in your briefcase.

Provided by MIIX Financial Services

The MIIX Toolkit, designed specifically for physicians, explains how you can access:

- **MIIX Buying Service** — offering discounts up to 70% on quality medical and office supplies and equipment.
- **Equipment Leasing** — equipment lease financing and lines of credit at competitive rates.
- **Receivables Management** — providing collection of medical accounts receivable.

To find out more about this powerful resource,
call MIIX Financial Services at

1-800-227-MIIX.

Endorsed by the

Medical Society of New Jersey

MSNJ

MEDICAL INTER-INSURANCE EXCHANGE

P O W E R F U L P A R T N E R S H I P S



NEW DRUGS FOR CANCER

IMPROVED OUTCOMES FOR CANCER PATIENTS NO LONGER ARE IDLE PROMISES. ADVANCEMENTS INCLUDE NEW AGENTS, MODIFICATIONS OF ESTABLISHED TREATMENTS, AND MODULATION OF THE HOST-IMMUNE RESPONSE. THE OUTLOOK FOR CANCER PATIENTS IS ENHANCED EVERY DAY.

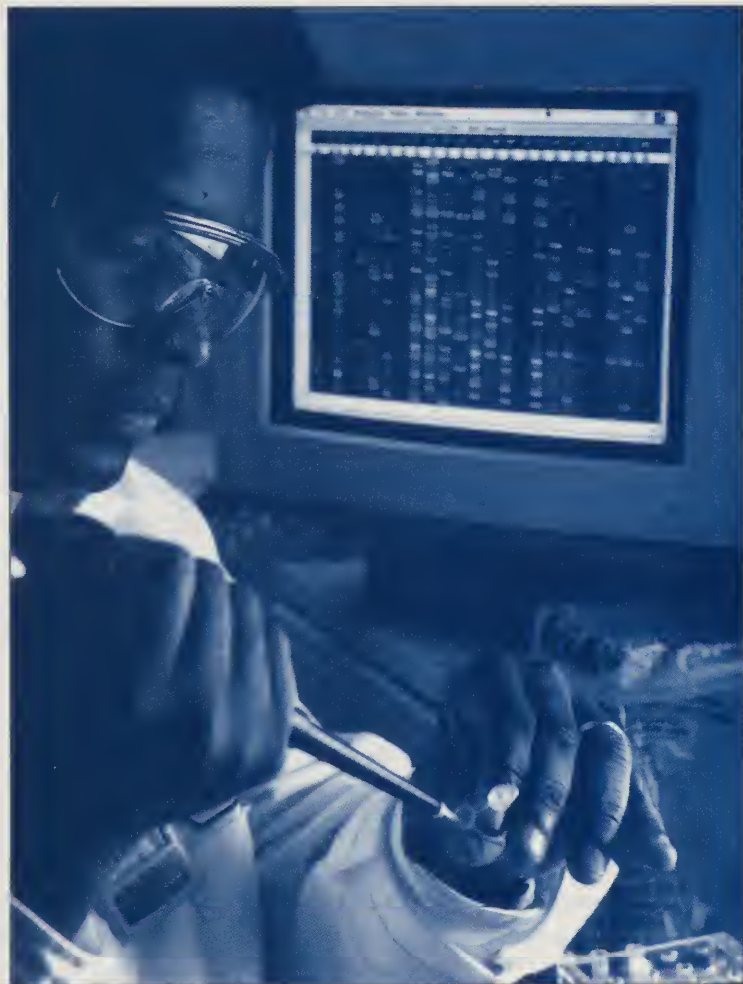
By Alan J. Lippman, MD

New drugs and altered techniques of application promise to improve outcomes for cancer patients. Advancements include new agents with novel mechanisms of action, modification of established treatments to enhance efficacy or limit toxicity, and modulation of the host-immune response. Additional areas of interest encompass the use of adjuncts to modify the effects of cancer on otherwise healthy tissues or organs. Other measures, directed toward control of toxicity, include agents to hasten myelopoietic recovery or to reduce nausea and vomiting, which frequently accompany the use of some chemotherapeutic drugs.

CHEMOTHERAPY

The taxanes are a new class of cytotoxic agents, which inhibit mitosis by disrupting intracellular mechanisms regulating formation of the mitotic spindle and potentiating release of cytokines. The parent compound, paclitaxel (Taxol®, Bristol-Meyers Squibb) and its analogue, docetaxel (Taxotere®, Rhône-Poulenc Laboratories), are particularly useful in inoperable breast cancer and in other solid tumors, including ovary, lung, esophagus, and head and neck cancers.

Hoffmann-La Roche researcher investigates genes and the link to cancer.



As with most agents, single agent therapy with taxanes provides a predictable response rate; however, combination therapy with certain non-cross resistant drugs without overlapping toxicities generally produces superior results. Useful combinations include paclitaxel and estramustine in hormone refractory prostate cancer, paclitaxel with carboplatin in lung cancer, and with ifosfamide in head and neck cancer. Paclitaxel also may act as a radiosensitizer, enhancing the effect of radiotherapy against lung cancer. Combinations of carboplatin and paclitaxel have been used in ovarian cancer and paclitaxel and doxorubicin in advanced breast cancer.

Studies have shown that docetaxel, because of its greater cytotoxicity and lack of cross resistance with other agents, including paclitaxel, may be particularly useful in combination with other agents for a wide variety of solid tumor types. Combinations of docetaxel and doxorubicin or cyclophosphamide have proved highly active against a wide variety of solid tumors, particularly breast cancer.

Vinorelbine (Navelbine®, Glaxo Wellcome), like paclitaxel, disrupts the mitotic spindle, although by a different mechanism. As a single agent, it has a role in the treatment of non-small cell lung cancer, advanced breast cancer and ovarian cancer. Its principal utility, however, may be in combination with

other agents, such as cisplatin and paclitaxel.

Combination therapy incorporating vinorelbine has contributed meaningfully to the management of advanced non-small cell lung cancer, a condition notoriously resistant to treatment.

Gemcitabine (Gemzar®, Eli Lilly) is a synthetic pyrimidine antimetabolite originally synthesized as an antiviral agent but subsequently found to have excellent in vitro antineoplastic activity. Its cytotoxic action appears due to the inhibition of DNA synthesis and repair. This drug shows clinical activity against a variety of solid tumor types, including non-small cell lung, breast, head and neck, bladder, colon and, particularly, pancreatic cancers. For the latter, this agent demonstrates a benefit in both disease palliation and survival, significant because of the generally poor condition of these patients and the limited therapeutic options available to them. Further study will be required to establish whether combinations with radiotherapy or other chemotherapeutic agents will enhance its utility.

Colorectal cancer is a difficult to treat malignancy often resistant to chemotherapy. For nearly 40 years, the only effective drug was fluo-

rouracil. Recently, a new agent, irinotecan (Camptosar®, Pharmacia & Upjohn), a semi-synthetic derivative of camptothecin, has proved to be a useful second-line agent for those patients no longer responding to fluorouracil. The drug acts as an inhibitor of the enzyme topoisomerase, an important regulator of DNA synthesis and repair. Future studies may further refine its role and application to other resistant malignancies, alone or in combination.

Chemically related to irinotecan, topotecan (Hycamtin®, SmithKline Beecham) is another promising topoisomerase inhibitor that provides a further therapeutic option for previously treated patients with advanced ovarian cancer showing progression after initial platinum-based chemotherapy. It also has activity in other tumor types, including small cell lung cancer, hematologic malignancies, and some pediatric neoplasms. Combination therapy with other agents and with radiation may afford an even wider scope of activity.

An unusual form of leukemia, so-called "hairy cell" leukemia, notable because of its distinctive appearance by light microscopy, shows striking response to a single course of therapy using only one new agent, cladribine (Leustatin®, Ortho Biotech). Overall response rates approach 90 percent, with nearly two-thirds of patients achieving complete remission. Only a single, seven-day course of treatment is required to achieve these results.

TOXICITY AMELIORATION

Although new agents may herald exciting new prospects for cancer

STUDIES HAVE SHOWN
DOCETAXEL TO BE USEFUL
IN COMBINATION WITH
OTHER AGENTS FOR
SOLID TUMOR TYPES.

treatment, refinement and modification of traditional agents may extend their scope of utility. Examples include amelioration of toxicity of the anthracyclines, such as doxorubicin (Adriamycin®, Pharmacia & Upjohn) and modulation of fluorouracil (Roche Pharmaceuticals).

Anthracycline antibiotic use is limited by cardiac toxicity. Risk factors include cumulative dose, radiation to the chest and mediastinum, age and pre-existing myocardial impairment. Dexrazoxane (Zinecard™, Pharmacia & Upjohn) prevents anthracycline cardiac toxicity by intracellular chelation of iron. Thus, higher cumulative doses are possible, and the useful period can be extended. Dexrazoxane generally is recommended beyond a cumulative total dose of doxorubicin of 300 mg/M². Another way to reduce dose-limiting toxicity is to encapsulate drug in liposomes, closed vesicular structures providing a safe vehicle for drug delivery to sites of disease while limiting exposure of normal tissues. Examples using this approach include liposomal doxorubicin (Doxil®, Sequus) and liposomal daunorubicin (DaunoXome®, NeXtar Pharmaceuticals).

Fluorouracil has proved one of the most useful cytotoxic agents of the past 40 years. Enhancement of its action through modulation of its metabolic pathways has been pursued actively in recent years. The

HAIRY CELL LEUKEMIA SHOWS RESPONSE TO A SINGLE COURSE OF THERAPY USING A NEW AGENT, CLADRIBINE.

best known of these modulations, now used commonly in adjuvant therapy of colorectal cancer, involves leucovorin, which stabilizes inhibition of thymidylate synthase, an important enzyme in its metabolic pathway.

Other drugs have been shown to enhance the cytotoxicity of fluorouracil. These include dipyridamole, phosphonacetyl-L-aspartate (PALA), methotrexate, hydroxyurea, and interferons. Tegafur, a fluorouracil precursor, developed in Japan during the 1980s, and UFT, and oral form of tegafur, produce more sustained levels of fluorouracil.

BIOLOGIC THERAPY

A new era in biologic therapies has led to clinical benefit by modulating host immune mechanisms. Interferons have been in clinical use since the early 1980s. These agents have multiple mechanisms of action, including direct anti-proliferative action against tumor cells as well as modulation of host immune responses. Clinical indications for interferons include hairy cell leukemia, AIDS-related Kaposi's sarcoma, chronic myelocytic leukemia, melanoma, renal cell carci-

noma, myeloma, and certain lymphomas.

Unlike interferons, which have antiproliferative action, interleukins have no direct impact on cancer cell growth, mediating all of their activity by modulation of immune reactions. The interleukins have found the greatest application in melanoma, hematologic malignancies, and renal cell cancer.

Monoclonal antibodies are so-called "magic bullets" that seek out and bind to specific antigenic proteins, thus raising the possibility of specific, directed therapy. One of the first commercially available monoclonal antibodies is rituximab (Rituxan®, Genentech and IDEC), a genetically engineered monoclonal antibody directed against the CD20 antigen found on the surface of normal and malignant B lymphocytes. Treatment with this agent results in a rapid and sustained depletion of circulating and tissue-based B cells, reducing disease burden. The drug is indicated for the treatment of patients with relapsed or refractory low-grade lymphoma.

Substantial evidence now exists regarding the importance of angiogenesis for tumor growth and metastasis. As targets for biologically directed therapy, angiogenesis inhibitors fall into two categories, protease inhibitors, which prevent penetration of the basement membrane, and endothelial cell growth factor inhibitors.

Currently undergoing testing are three angiogenesis inhibitors, tecogalan, recombinant human platelet factor 4, and TNP-470. Although still early in development, these proteins appear to show promise in

such difficult to treat conditions as AIDS-related Kaposi's sarcoma.

TOXICITY AMELIORATION

Agents to modulate the toxic side effects of chemotherapy are commanding interest. Several years of experience have made filgrastim (Neupogen®, Amgen) and sargramostim (Leukine®, Immunex) important constituents of treatment programs to restore leucocytes following myelosuppressive therapy. This year has brought oprelvekin (Neumega®, Genetics Institute), a platelet growth factor intended to reduce the need for platelet transfusions following chemotherapy.

GASTROINTESTINAL TOXICITY

Traditionally, nausea and vomiting associated with chemotherapy have made tolerance to this form of treatment problematic for many cancer patients. Better understanding of the pathophysiology of emesis had led to the introduction of new, effective agents that have markedly reduced the incidence of these symptoms. Arguably the most important of these, the 5-HT₃ antagonists, now are commonly used to prevent nausea and vomiting associated with highly emetogenic chemotherapy.

The 5-HT₃ antagonists currently on the market include ondansetron (Zofran®, Glaxo Wellcome), granisetron (Kytril®, SmithKline Beecham), and dolasetron (Anzemet®, Hoechst Marion Roussel). These agents, selective antagonists of 5-HT₃ receptors in the brain and gastrointestinal tract, may be used individually or in combination with other effective agents.

Diarrhea also can be a troublesome side effect of treatment, par-

ticularly with leukovorin/fluorouracil and irinotecan. A variety of pharmacologic interventions have been employed for control of intestinal hypermotility, which can rapidly lead to dehydration. Standard agents such as opioids (loperamide, diphenoxylate, or codeine), anti-cholinergics (atropine or scopolamine), absorbants, and adsorbants have been joined by omeprazole, cholestyramine, anti-prostaglandin agents, and miscellaneous inhibitors of endocrine and/or gastrointestinal secretions, such as clonidine and cyproheptadine or methysergide, peripheral serotonin antagonists.

Effective anti-diarrheal control now can be provided by a synthetic amino acid peptide resembling somatostatin, a hormone that inhibits growth hormone release from the hypothalamus and insulin release from pancreatic islet cells. Somatostatin inhibits gut motility and decreases release of enteric hormones and neurotransmitters with

direct effects on ion transport, stimulating absorption and inhibiting secretion. Octreotide (Sandostatin®, Novartis) now is approved for the treatment of diarrhea and flushing associated with carcinoid tumors and the diarrhea associated with VIPomas. Treatment of chemotherapy-associated diarrhea also may be an indication.

BONE METASTASES

Among the treatments designed to ameliorate the complications of cancer itself are those that address the consequences of bone metastases. Cancer patients with skeletal metastases frequently develop intractable bone pain and are at risk for pathological fractures. Bone marrow suppression, hypercalcemia, and nerve compression syndromes also occur, and all of these conditions can be distressing or disabling. Bisphosphonates, exemplified by etidronate (Didronel®, MGI Pharma) and pamidronate (Aredia®, Novartis), both specific inhibitors of osteoclastic activity, are effective in the treatment of hypercalcemia associated with malignancies and can reduce bone pain and promote healing of lytic lesions.

CONCLUSION

The outlook for cancer patients is improving. New agents to treat malignancies, modification of older, established agents, novel approaches addressing the phenotypic manifestations of cancer, control of toxicities related to cancer treatment, and adjuncts to deal with the complications of cancer itself represent important gains and foretell a hopeful future as treatments turn from the purely empiric to the more rational.

IMPORTANT GAINS IN
CANCER RESEARCH
FORETELL A HOPEFUL
FUTURE FOR
CANCER PATIENTS.

*Third Annual
Kessler
Manual Medicine Course*

**Basic Principles of Manual
Medicine**

August 19-21, 1998

**Counterstrain Techniques,
Trigger Point Treatment and
Beyond**

August 22-24, 1998


Manual Medicine continues to develop as a primary tool in patient management for the care of acute and chronic pain...and as such it has become an integral part of the practice of clinical medicine.

Internationally known faculty, Doctors Gilliar and Glassman will utilize a variety of approaches including Didactic Teaching, Step-By-Step Presentations, Hands-on Laboratory Sessions, and Clinical Problem Solving.

Faculty: Wolfgang Gilliar, DO
*San Francisco International Manual
Medicine Society*
Jerel Glassman, DO
*University at Michigan State; Stanford
University*
Ronald Tolchin, DO
Nova Southeastern University

Dates: Basic Principles (\$700)
August 19-21, 1998
Counterstrain Technique, Trigger
Point and Beyond (\$600)
August 22-24, 1998

Sponsored by...

 **KMRREC - Kessler Medical Rehabilitation
Research & Education Corporation and
UMDNJ - New Jersey Medical School,
Department of PM&R**



Seating strictly limited.

Reserve your space and register today! Call
KMRREC at 800-248-3221 (ext. 6812) for a course
brochure or visit us at www.kmrrec.org

Malpractice insurance policies are strange animals. Beware of the ones with tails.

Most New Jersey malpractice insurance policies require you to purchase a reporting endorsement — known as a tail — to protect against claims that may occur during retirement. B.C. Szerlip offers a unique policy from an A+ rated company that does not include an annual tail premium. In fact, if you maintain coverage with us until retirement, you'll *never* have to purchase a tail, and you'll still be protected.

That's just one example of the creative ways that B.C. Szerlip has discovered to help doctors with their long-range financial planning.

At B.C. Szerlip, we take a big-picture view of your practice, offering you comprehensive insurance and financial planning services. You can benefit from our nearly two decades of experience providing malpractice insurance for medical offices both large and small. In addition, our financial planners can offer strategic guidance for the overall health of your business affairs, so you can stay focused on the health of your patients.

We'd like to give you a taste of our full-service approach by sending you *The Managed Care Survival Kit for Physicians*. To receive your complimentary copy of this useful guide, please call us at 800-684-0876.

BCSZERLIP INSURANCE AGENCY INC.

99 WOOD AVENUE SOUTH, PO BOX 217
ISELIN, NJ 08830-0217
800-684-0876 • 732-205-9800
FAX: 732-205-9496
E-MAIL: bcszerlip@aol.com

*Professional Insurance Services
for Health Care Providers*

CALENDAR

E V E N T
D A T E
L O C A T I O N
A u g u s t

Intensive Review of Internal Medicine	August 2-7, 1998	College of Physicians and Surgeons, New York, 212.781.5990
--	------------------	--

S e p t e m b e r

Renal Biopsy in Medical Diseases of the Kidneys	September 16-19, 1998	College of Physicians and Surgeons, New York, 212.781.5990
--	-----------------------	--

Psychiatry Update 1998	September 26, 1998	College of Physicians and Surgeons, New York, 212.781.5990
-------------------------------	--------------------	--

O c t o b e r

Controversies in Women's Health	October 3, 1998	College of Physicians and Surgeons, New York, 212.781.5990
--	-----------------	--

Sports Medicine '98	October 7, 1998	MSNJ, Lawrenceville, 609.896.1766
----------------------------	-----------------	-----------------------------------

Cancer Survivorship	October 8-10, 1998	Caesars Hotel, Atlantic City, 212.366.6565
----------------------------	--------------------	--

Fall Forum: Managed Health Care	October 11-13, 1998	Marriott Hotel, Washington, DC, 1.800.642.2515
--	---------------------	--

Lyme Disease	October 17, 1998	College of Physicians and Surgeons, New York, 212.781.5990
---------------------	------------------	--

HealthPack '98	October 20-21, 1998	Hyatt Regency, Tampa, 717.291.5609
-----------------------	---------------------	------------------------------------

Dermatology for the Primary Care Physicians	October 31, 1998	College of Physicians and Surgeons, New York, 212.781.5990
--	------------------	--

N o v e m b e r

MRI Symposium	November 6-8, 1998	Radiological Society of New Jersey, Somerset Marriott, AMNJ, 609.275.1911
----------------------	--------------------	--

Psychiatry in Primary Care	November 14, 1998	College of Physicians and Surgeons, New York, 212.781.5990
-----------------------------------	-------------------	--

You take care of your patients. We'll take care of the health of your practice. Our group of health care accounting specialists provides the medical community with the right type of analysis and counseling to be successful.

Since we're dedicated to increasing your profitability, never simply reporting it, we'll see

to it that your practice stays healthy for many years to come. To experience our unique approach, please call Ira S. Rosenbloom, Managing Director, at 973-882-1100.

PRACTICE **GOOD FINANCIAL** **MEDICINE.**



Mintz Rosenfeld & Company LLC

Profitability Consultants • Certified Public Accountants

60 Route 46 East, Fairfield, NJ 07004

Tel: 973-882-1100 Fax: 973-882-1560

OUR FOCUS IS YOUR SUCCESS.



ANTI-AGING MEDICINE

1998 Board Certification Examination and Clinical Training Seminar August 15, 16, 17 in NYC.

Call for credentials and application

(773) 528-4333 • Fax (773) 528-5390

www.worldhealth.net

Representing 5,000 physicians and scientists in 40 nations.

Specializing in the Business of Health Care

Physician Practice Assessment/Contract Negotiations
Fee Schedule & Super Bill Analysis/New Practice Set-Up
Coding Issues/Risk Management

Call Evelyn Gross, CMM, CPC
(201) 261-4030

HUNTER HEALTHCARE SERVICES

Division of RD Hunter & Company LLP
Paramus, NJ New York City

A N N O U N C I N G N E W J E R S E Y ' S F I R S T

Executive MBA in Health Systems Management

Managing Change in the Business of Health Care

Are you among the growing number of physicians considering an MBA? In today's managed care environment, physicians are being called upon to be smart fiscal managers as well as skilled care providers.

Fairleigh Dickinson University's new 21-month weekend program is designed to build the leadership skills of administrators and physicians in the collaborative management of health care systems. Its weekend format makes it possible for physicians to earn an MBA without interrupting their medical practices. Studies include a two-week summer symposium on international health care issues in England.



*Fairleigh Dickinson
University*

Applications for the Fall 1998 inaugural class are now being accepted. Instruction will take place on FDU's convenient Teaneck-Hackensack Campus. Applicants must have at least seven years of experience.

For a brochure and application packet, contact the
Office of Executive & Special Programs by

Phone: **201/692-7206** or

E-mail: **shurdom@alpha.fdu.edu**

Silberman College of Business Administration

A NEW JERSEY LEADER IN EXECUTIVE MBA PROGRAMS

CLASSIFIED ADS

110 OPENINGS PHYSICIANS (ALPHABETICAL BY SPECIALTY)

BC/BE ANESTHESIOLOGIST

Pain Management Only—New Jersey (Central/Northern—½ hr. from N.Y.C.). Outstanding private practice opportunity for BC/BE Anesthesiologist. Pain Fellowship is a plus. F/T or P/T. Most established pain group in the state. No night calls or wknds. Avail. 08/01/98. Fax short CV & cover letter to 732-651-0375.

DERMATOLOGY PRACTICE OPEN OPPORTUNITY

Thriving well-established practice on Jersey Shore seeking energetic individual to assume practice. Can also accommodate P/T work, 1-2 days/wk; terms negotiable. Confidential Box #137, New Jersey MEDICINE, 370 Morris Avenue, Trenton, NJ 08611.

INTERNAL MEDICINE

Internal Medicine. Family Practice. Mercer County/Princeton Area. Seeking BC/BE Internist/Family Practitioner to join busy medical practice in the Mercer County, Princeton Area. Competitive Salary, full Benefits Package. Recent Residency Graduates welcomed. Contact Dr. Joseph De Blasio. 609-586-6006.

200 PRACTICE FOR SALE

ENT PRACTICE

Gen ENT practice, solo in own building—established 28 yrs—South Jersey Shore area—15 min to Atl. City, 1 hr to Philadelphia. Enjoy the Shore, fishing, etc. Call 609-823-4273.

300 OFFICE RENTALS AND LEASES

EDISON

Office Space—Edison Medi-Plex Building opposite J.F.K. Hosp. Fully equipped, turn-key. Rent day, full day, night. 732-494-6300.

FORT LEE

Medical Office Space, 3 treatment rooms, consult/private office, reception area, fully furnished, turn key, handicap accessible, ample parking, good location, modern and professional. Available Tuesdays, Thursdays and Saturdays, \$900. 5 minutes from GWB. (201) 886-8755.

MILLBURN

Medical Arts Building. Millburn Avenue. Fully equipped, turn key. Rent day, 1/2 day, night. Call 973-376-8670.

MOORESTOWN, NJ

Medical Center. Excellent primary care network—Family Practice/Pediatrics/OB-GYN. Need medical and surgical specialties. Several offices available. Excellent Location. 609-235-2651.

MOUNTAIN LAKES PARSIPPANY AREA

Get in on the ground floor! Now leasing new office building excellent location on Rt. 46. Medical suites from 1000-6000SF. Will build to suit. 973-316-6900.

310 OFFICES TO SHARE

PRINCETON AND/OR MARGATE

Princeton and/or Margate space to share bright, dynamic rehab. Center. Flexible depending on needs. Call Val 609-581-2400.

325 MEDICAL BUILDING SALE OR LEASE

TEANECK (BERGEN COUNTY)

For Sale. Office Condo in Profess Bu 1,100 Sq Ft, 7 Rooms with 4 Exam Rooms. Lower Floor. Ideal Central Location on Lane. Available Immediately. Asking \$14 Call 201-385-3008.

420 FINANCIAL SERVICE

ALTERNATIVE FINANCING/MEDIATION

Where do you go when banks say "NO"? Our company has access to an extensive network of Alternative lenders willing to go where traditional banks won't. Business Debts that are overdue can cause real problems. We resolve debts by skillful negotiation. 732-416-0100.

510 EQUIPMENT WANTED

USED DEXA MACHINE

Wanted: A used DEXA (Bone Density Machine) preferably a Hologic. Cash or installment. Please call 24 hours, Page 421-9795 or 609-586-1100 or Eves 609-924-4704 for doctor.

EMERGENCY PHYSICIANS

Emergency Physician Associates, a Team Health affiliate, is seeking quality ED physicians for a variety of practice opportunities in NJ, PA, DE, MD, NC and NY.

We offer physicians competitive compensation, flexible schedules, malpractice insurance, a variety of practice settings, and supportive Medical Directors.

Interested candidates may call

1-800-848-EPA-1.

OB/GYN PHYSICIAN

Are you a board certified or eligible OB/GYN Physician with a genuine commitment to the highest standards of patient care? A fast-growing, highly respected southern New Jersey private practice, affiliated with Memorial Health ALLIANCE of Mount Holly, has an exceptional full-time opportunity.

As an integral member of our dedicated team of physicians, you will provide the complete spectrum of OB/GYN services to women throughout the Burlington County area. This position offers highly competitive salary and benefits, along with modern work location convenient to Atlantic City and the Jersey shore, New York City and Philadelphia. PRINCIPALS ONLY should FAX (609) 265-7899 or send CV to Human Resources, ALLIANCE Medical Management, Inc., 2615 Rte. 38, Suite 201B, Mt. Holly, NJ 08060. EOE, M/F.

ALLIANCE

Alliance Medical Management, Inc.

The Medical Manager[®]

Practice Management Software

A fully integrated practice management solution

Over 16 years' experience in providing healthcare automation solutions

Provides an open system architecture and flexibility for specialized needs

Designed for small group practices to large Integrated Delivery Systems

Overwhelming national presence

Learn more about how Medical Manager Corporation and The Medical Manager system can meet your needs. Contact us at 800.677.7784, 201.808.0088, or www.medicalmanager.com.

Medical Manager

Corporation

RTI, Inc. and Medix

Empowering the Industry Through Partnership



Today, it is not enough to know the latest technology. Reach over the horizon, and grasp the technologies that will change the future...

Emerging Technologies: New Frontiers in Medical Rehabilitation September 25 & 26, 1998

21st Century Medical Rehabilitation will not just improve function, but will embrace interventions that reverse the impairments that underlie chronic disability.

*Transplantation * Telemedicine *
Sensory Rehabilitation * Robotics *
Voice Activated Computers *
The "Smart House" * Neural Prostheses *
Virtual Reality *
Complementary & Alternative
Therapies * Pharmacological
Approaches to Brain Damage
Recovery * Neural Regeneration *
and evolutionary developments of
today's technologies and therapies...*

*What is the impact on the patient...
what is the impact on society?*



Mark your calendar today for September 25 & 26, 1998 for *Emerging Technologies*, at the Kessler Conference Center, West Orange, New Jersey. CMEs and CEUs will be available. Call KMRREC - Kessler Medical Rehabilitation Research & Education Corporation at 800-248-3221 (ext. 6812) for a brochure and more information or visit us at www.kmrrec.org



THE MEDICAL SOCIETY OF NEW JERSEY CLASSIFIED ADVERTISEMENT INSERTION REQUEST

RATES

(Placement in New Jersey *MEDICINE* OR on WEB Site)

	<u>New Jersey <i>MEDICINE</i></u>	http://www.msnj.org <u>WEB Site</u>
Per Month—Non-Members		
Minimum 45 words	\$ 45.00	
plus each word		
over 45 words	\$ 1.00	
Per Month—Members		
Minimum 45 words	\$ 30.00	
plus each word		
over 45 words	\$ 1.00	
Per Month—		
Minimum 45 words		\$ 45.00
plus each word		
over 45 words		\$ 1.00

(Placement in New Jersey *MEDICINE* AND on WEB Site)

	<u>New Jersey <i>MEDICINE</i></u>	http://www.msnj.org <u>WEB Site</u>
Per Month—Non-Members		
Minimum 45 words	\$ 45.00	\$ 36.00
plus each word		
over 45 words	\$ 1.00	\$.80
Per Month—Members		
Minimum 45 words	\$ 30.00	\$ 36.00
plus each word		
over 45 words	\$ 1.00	\$.80

PREPARE YOUR COPY ON A SEPARATE PAGE AND ATTACH TO THIS ORDER FORM

INSERTION AUTHORIZATION

Name _____ MSNJ Member? Yes _____ No _____
 Company _____ Telephone Number _____
 Address _____ Fax Number _____
 City _____ State _____ ZIP _____
 New Jersey *MEDICINE* Issues _____
 Web # of 30 Day Insertions _____

New Jersey *MEDICINE*

Non-Member
 Minimum 45 Words \$ _____ 45.00
 + Each Add'l Word @\$1.00 \$ _____
 Per Issue \$ _____
 X Number of Issues
 AMOUNT DUE \$ _____

MSNJ WEB SITE

Non-Member or Member
 Minimum 45 Words \$ _____ 45.00
 + Each Add'l Word @\$1.00 \$ _____
 Per Month \$ _____
 X Number of Months
 AMOUNT DUE \$ _____

New Jersey *MEDICINE*

Member
 Minimum 45 Words \$ _____
 + Each Add'l Word @\$1.00 \$ _____
 Per Issue \$ _____
 X Number of Issues
 AMOUNT DUE \$ _____

MSNJ WEB SITE WITH NEW JERSEY *Medicine* Placement

Non-Member or Member
 Minimum 45 Words \$ _____
 + Each Add'l Word @\$.80 \$ _____
 Per Month \$ _____
 X Number of Months
 AMOUNT DUE \$ _____

TOTAL DUE \$ _____ ALL CLASSIFIED ADS MUST BE PRE-PAID

Please make check payable to "Medical Society of New Jersey"

Mail to: Classified Ad Department
 370 Morris Avenue
 Trenton, NJ 08611

Tel: 609-393-7196
 Fax: 609-393-3759

LIVING ON EASY STREET

For New Jersey seniors, life is about to get a lot easier, says the New Jersey Department of Health and Senior Services (DHSS). The New Jersey Easy Access, Single Entry (NJ EASE) program streamlines the senior services network, making it easier for older New Jerseyans—and their families and physicians—to access information and services. With one telephone call, get one-stop information on home- and community-based services like



MS Commissioner
Fishmon

home-delivered meals, health insurance counseling, assisted living facilities, and alternate family care. To obtain a free NJ EASE brochure, MSNJ members may contact Lisa Hibbs at MSNJ (telephone 609.896.1766, ext. 258 or e-mail ldownsmsnj@worldnet.att.net).

GREAT COVER UP

Health care professionals—especially individuals with ongoing latex exposure—are at risk for developing latex sensitivity (see page 22). Eight to 12 percent of regularly exposed health care workers are sensitized to latex. Symptoms include asthma, irritant and allergic contact dermatitis, and latex allergy (hives, wheezing, runny nose, itchy eyes). A booklet prepared by the U.S. Department of Health and Human Services, *Preventing Allergic Reactions to Natural Rubber Latex in the Workplace*, is available free of charge by contacting Lisa Hibbs at MSNJ, telephone 609.896.1766 ext. 258 or fax 609.896.1368.



A UNIVERSITY MAN

He has left an everlasting mark in the Garden State. His efforts and dedication have touched the lives of virtually every New Jerseyan. He is Stanley S. Bergen, Jr., MD, UMDNJ's first president. He has created the largest free-standing public health sciences university, with seven schools, five campuses, over 5,000 students, and an endowment of more than \$100 million.

Retiring after 27 years as president of UMDNJ, Bergen will not take on

an idle, leisurely life of retirement. Bergen will transition into a new role as volunteer chair of the Board of Directors of The Hastings Center, devoted to research, study, and education of biomedical issues and the environment. He also plans to integrate teaching assignments at UMDNJ and The Hastings Group into his schedule.



Stanley S.
Bergen, Jr., MD

IN HIS FATHER'S FOOTSTEPS

As one of his last official functions as president of MSNJ, Carl Restivo, Jr, MD, had the honor of presenting his father—Carl Restivo, Sr, MD—with the Golden Merit Award at the MSNJ Annual Meeting. "In the 21 years I have been attending the MSNJ Annual Meeting, I have never missed a Golden Merit Award ceremony," he noted in his speech at the ceremony. "Today, I also will have the unique pleasure of presenting the Golden Merit Award to my father." Also receiving the award were Henry R. Liss, MD, chair of the *New Jersey Medicine* Review Board and vice-chair of the Council on Communications and Stanton Sykes, MD, who contributed his article series, "Musings of a Medic," to *New Jersey Medicine*. Since 1957, MSNJ celebrates those physicians who have served their patients for 50 years with the Golden Merit Award.



Dr. Restivo (left) presented MSNJ's prestigious Golden Merit Award to his father.

MOVERS & SHAKERS

Arthur Krosnick, MD, a past editor of *New Jersey Medicine*, has been named the 1998 Outstanding Physician Educator in the Field of Diabetes Award from the American Diabetes Association.



Arthur Krosnick, MD

The New Jersey Academy of Ophthalmology has elected MSNJ member **Mark S. Goldfarb, MD** to its Board of Governors.

Saint Barnabas Medical Center announces that MSNJ member **Richard Lander, MD**, has been elected clinical chief of the Department of Pediatrics.



Todd A. Gruber, MD

MSNJ member **Todd A. Gruber, MD**, has been named medical director of Monmouth Health Center at Broadway, Monmouth Medical Center's primary care facility in downtown Long Branch.



Richard P. Oths

Richard P. Oths, president and chief executive officer of Atlantic Health System in Florham Park, was elected to serve a one-year term as chair of the 112-member New Jersey Hospital Association.

A new **School of Public Health** is to be added to the UMDNJ system. With offerings of master's and doctoral degrees, students will begin enrolling in the school starting in September 1999.

MSNJ members **Edward W. Forbes, MD**, and **Benjamin O. Zamora, MD**, received three-year appointments as Cancer Liaison Physicians for the Hospital Cancer Program at Northwest Covenant Medical Center and at St. Elizabeth Hospital, respectively.

BLOOD LETTING

Jill Burnley, with Jo Valenti, RN, manager of Hackensack University Medical Center's Center for Bloodless Surgery and Medicine, became the first participant of the center's ID Bracelet program. The ID bracelet ensures that patients will not receive a blood transfusion if they had expressed a desire to participate in the Center for Bloodless Medicine and Surgery.



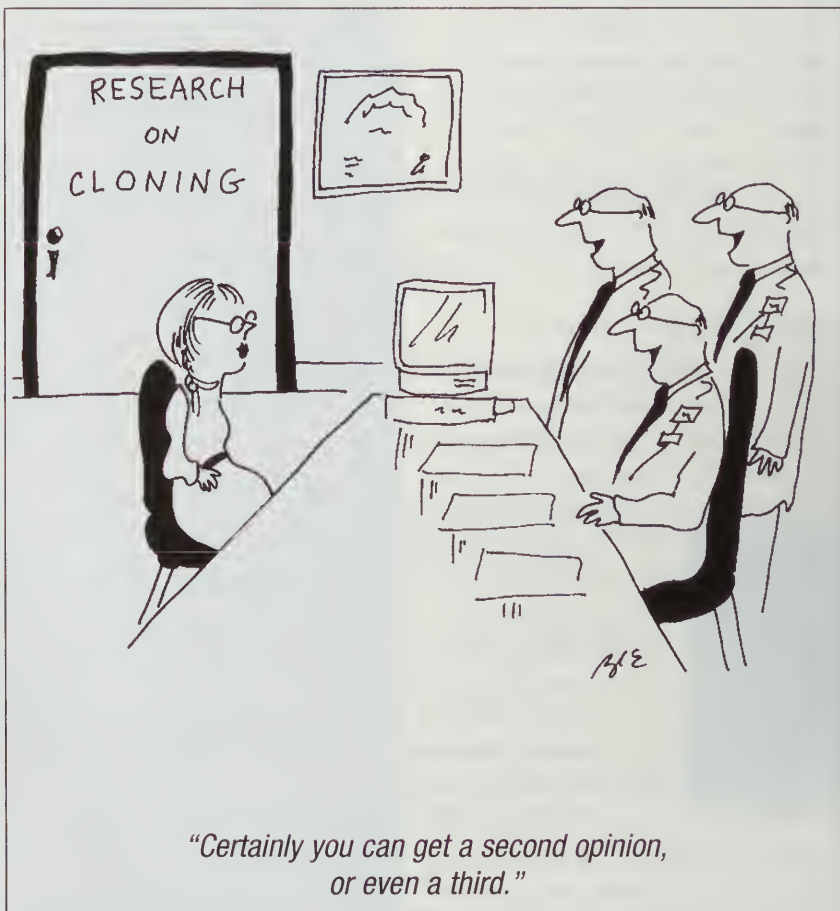
Jo Valenti and Jill Burnley

SINAGRA HONORED

Republican Health Committee chair Jack Sinagra of Edison has been named a recipient of one of the top awards of the American Medical Association. He will receive the Nathan Davis Award on September 23. The award comes in recognition of Senator Sinagra's support of tobacco control, his sponsorship of the Health Care Quality Act, and his sponsorship of the new prompt pay bill. Other New Jerseyans receiving the honor previously include Congresswoman Marge Roukema and Leah Z. Ziskin, MD.



Jack Sinagra



New Jersey Medicine (ISSN 088-5842-X) is published monthly (since 1904) under the direction of the Council on Communications by the Medical Society of New Jersey (MSNJ), Two Princess Road, Lawrenceville, NJ 08648. Printed in Lancaster, PA, by Lancaster Press. Printed in USA. Whole number of issues 1129. Member's subscription (\$10) is included in MSNJ dues. Rates for nonmembers are \$50; outside USA, add \$20. Single copy is \$7.50. Periodicals postage paid at Trenton, NJ, and Lancaster, PA. Copyright 1998 by MSNJ. July 1998. Internet address: <http://www.msnj.org>. E mail address: info@msnj.org. 609.896.1766. FAX 609.896.1368. Postmaster: Send address changes to *New Jersey Medicine*, Two Princess Road, Lawrenceville, NJ 08648. The appearance of advertising *New Jersey Medicine* is not a MSNJ guarantee or endorsement of the product or service, by the advertiser. When MSNJ has endorsed a product or program, that will be expressly noted.

LIFSHUTZ, POLLAND & ASSOCIATES, P.C.

**THE LAW FIRM THAT SPECIALIZES IN HEALTH
CARE REPRESENTATION OF PHYSICIANS AND
OTHER HEALTH CARE PROFESSIONALS.
OUR AREAS OF EXPERTISE INCLUDE:**

1. Managed Care Contracts with MSOs and HMOs.
2. Health Care Mergers/Joint Ventures/Acquisitions.
3. Development and implementation of Compliance Audits and Plans.
4. Respresentations in Board of Medical Examiner Cases.
5. Asset Protection/Estate Planning as protection against malpractice suits.
6. Federal and State Anti-Kickbacks/Stark/Safe Harbor representation.
7. Medicare/Medicaid/Third Part Audits

**OUR EXPERT STAFF CONSISTS OF SPECIALIZED
ATTORNEYS AS WELL AS PHYSICIAN-ATTORNEYS.**

LIFSHUTZ, POLLAND & ASSOCIATES, P.C.

ATTORNEYS AT LAW

**326 LAFAYETTE AVE., HAWTHORNE, NJ 07506
(201) 427-2040**

**675 THIRD AVENUE, NEW YORK, NY 10017
(212) 949-8484**

Web: Lifshutz-Polland.com



Druker, Rahl & Fein

**Business Consultants
Certified Public Accountants**

We have your prescription to profitability

**We're Druker, Rahl and Fein, the accountants and advisors
to physicians and health care providers.**

...Managed Care..Government Regulations

..the industry is changing..quickly.

How will these changes affect your practice?

You have questions and you need answers.

**Our medical services experts will assist you
in developing a strategy to**

succeed in this dynamic environment.

Leaders in:

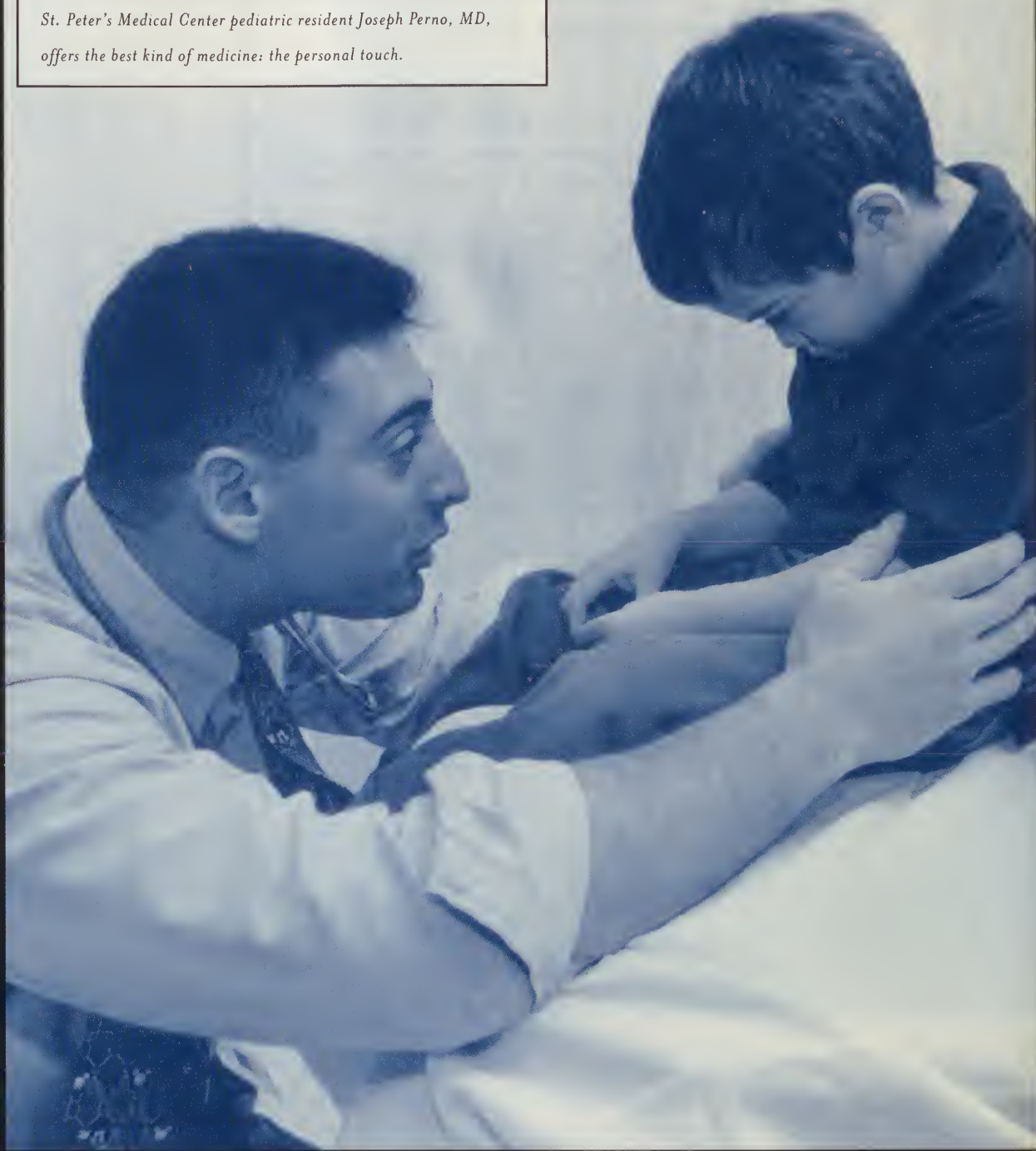
**Cost Accounting • Strategic Planning • Group Practice Formation • Tax
Managed Care Analysis • Practice Valuations • Practice Management**

200 Canal Pointe Boulevard • Princeton, NJ 08540-5998 • 609-243-9700 • FAX 609-243-9799

Contact Robert J. Rahl, CPA

Photo Finish

The emergency room can be an intimidating place for some patients. St. Peter's Medical Center pediatric resident Joseph Perno, MD, offers the best kind of medicine: the personal touch.



We welcome contributions to Photo Finish (color or black-and-white). Please include a 50-word description of the photograph. Send to Editor, New Jersey Medicine, Two Princess Road, Lawrenceville NJ 08648. Photographs will be returned.

NEW JERSEY MEDICINE

HEALTH CARE IN THE GARDEN STATE

AUGUST 1998

Paradise Lost

*The
high
cost
of
infertility*



plus
Putting the Public
back in public health

Texas Medical Assoc
Journal Office
401 West 16th St
Austin, TX 78701

Y - O - U - R

PRACTICE

MADE MORE

PERFECT

WITH OVERHEAD EXPENSE INSURANCE FROM BLANKSTEEN

If you get sick, we'd like to help keep your practice well with overhead expense coverage that can reimburse office salaries, rent, insurance premiums, and utilities during an extended disability. Your needs are special, so call and talk with us. The only time to draw a blank in your insurance is when you fill it in with Blanksteen.



The _____ steen Companies

The Blanksteen Companies 253 Washington Street Jersey City, NJ 07302 201-333-4340 1-800-BLANK-AG
The Blanksteen Companies 161 William Street New York, NY 10038 212-732-9435 1-800-BLANK-AG
The MEDICAL SOCIETY OF NEW JERSEY endorsed plans, including Professional Overhead Expense underwritten by National Casualty Company.

AUG 18 1998

AUSTIN, TEXAS

Newswatch

Health care in your own backyard

In this era of mergers, let's remember that greatness in size can reduce nimbleness and efficiency. The Minnesota lawyers who produced the landmark settlement against the tobacco industry succeeded as a single law firm confronting a Godzilla force of 30 firms.

Like Gopher State Attorney General Hubert "Skip" Humphrey's team, we in the Garden State often seek to function in small groups, preserve limited enterprises, and "act locally." This attitude is reflected in *Health Policy for Low-income People in New Jersey*, a new report by field researchers for The Urban Institute of Washington, DC. The report describes the state's "mixed approach" combining market forces with the safety net.

Catastrophic care aid, KidCare, HealthStart, vaccine assistance, and numerous other programs were launched in recent years here as partial, not total, solutions. Each small in itself, as a whole these programs serve as a comfortable quilt rather than an ion-blazing space heater. Perhaps partly as

a consequence, our kids tend to do better on many health indices than might be expected in a state with heavy inner-city concentrations, a significant north-south divide, and astonishing demographic diversity.

HMOs defend turf.

For the first time in four years, health care has taken center stage in the nation's political arena, as HMO patient rights have emerged as a major partisan issue. Interestingly, "the vast majority" of 800 business executives surveyed by the Kaiser Family Foundation supported proposals that could add as much as \$15 to monthly premiums, and one-half said they would absorb all the costs, according to *Medicine & Health (M&H)*.

Republican Assemblymen Guy F. Talarico of Paramus and Nicholas Asselta of Vineland report similar support from local business people, many of whom have had their own experiences with managed care.

However, most employers are not rushing to foster patient choice of health plan. The Center for Studying Health System

Change reports in its summer *Data Bulletin* that only 17 percent of private employers, including only one-third of firms with at least 100 employees, offer a choice.

When patients have a choice, they can be skeptical about HMOs. A literature review summarized in the Agency for Health Care Policy and Research (AHCPR)'s *Research Activities*, found that HMOs produced consistently poorer results than other plans in both patient

The nation's biggest health care program, Medicare, is getting more complicated. Seniors soon will be able to select new options to traditional fee-for-service Medicare and HMOs. The options include provider-sponsored organizations, preferred provider organizations, private fee-for-service plans, medical savings accounts, and private contracting. MSNJ has begun holding seminars to discuss the options.

satisfaction and access to health care. HMO results were worst among patients who were sick or poor.

Network role evolves.

Will smaller provider networks hold down costs? *M&H* responds with "a resounding 'We haven't got a clue.'" On the one hand, Ox-

ford Health Plans ran into financial trouble with a broad-access approach. On the other hand, patients are flocking to broader plans that eschew capitation.

The newsletter quotes Geoffrey Harris, managing director of Salomon Smith Barney, as saying that the question boils down to whether managed care is a device to concentrate purchasing power or an information-based system of care management, disease management, and disease prevention. Presumably, the former holds down costs, while the latter maximizes benefit-cost ratios. One hopes that the former is evolving into the latter.

The newsletter goes on to observe that physician-run independent practice associations (IPAs) are starting to take on more cost and quality control in imitation of HMOs. Brent Miller, vice-president of the American Medical Group Association, foresees "several years of turmoil." The upheaval includes the current trend to pay primary care physicians fee-for-service to maximize volume, while capitating specialists to minimize volume. *M&H* concludes that "turmoil" is "an understatement."

Capitation, by the way, is associated with greater physician input into coverage decisions. *Research*

Activities summarizes a study that found greater reluctance by managed care organizations to consult with fee-for-service physicians before denying benefits that could increase costs.

Affecting physician practices.

What's the best way to get physicians to apply new medical knowledge in their practices? Stephen B. Soumerai, ScD, of Harvard Medical School and colleagues found that advice from local physicians respected by their peers was far more effective than written materials. Again, act locally. The study involved 37 Minnesota hospitals' use of new American College of Cardiology and American Heart Association guidelines for greater use of aspirin, beta blockers, and thrombolytic drugs, and less use of lidocaine, in care of elderly heart attack victims.

Other *Research Activities* notes involve efforts to prompt older women to mention incontinence problems to their physician. Researchers found positive results with use of the question, "Do you consider this accidental loss of urine a problem that interferes with your day-to-day activities or bothers you in other ways?" In an examination of the growing use of carotid endarterectomies (removing plaque from the carotid

artery), now performed on more than 100,000 Medicare beneficiaries annually, David C. Hsia, MD, JD, of the Office of the Inspector General, found that perioperative mortality fell to 1.6 percent.

In the newsletter's lead story in June, economist Louise B. Russell, PhD, of Rutgers University's Institute for Health is credited for her research into the number of deaths that would be avoided annually if people would just—overcome the biochemistry of addiction and—quit smoking.

One-fourth of all oncology patients in nursing homes receive no pain medication, according to a study of 4,000 patients conducted by visiting professor Giovanni Gambassi, MD, of Brown University and colleagues. The study was reported in *JAMA* and summarized in *M&H*. Seeds of a scandal, these results pose a daunting challenge to the long-term care industry.

Maybe even the nursing home industry is getting too large. Philosopher and biologist Evan Eisenberg writes in *The Ecology of Eden*, "The bigger something gets, the farther its insides get from the outside world. If you want to exchange energy and matter with the outside world as efficiently as possible, you had better stay small."

Neil E. Weisfeld

“THERE IS
NOTHING MORE
EXHILARATING THAN TO BE
SHOT AT WITHOUT
RESULT.”



—WINSTON CHURCHILL

Princeton Insurance Company policyholders are winning the battle against frivolous professional liability claims: 95% of company-managed cases are resolved in our insureds' favor. A successful defense means an unscathed professional reputation *and* preservation of financial security.

In today's legal climate, even the best doctors must dodge a bullet now and then. To marshal the heavy artillery on *your* side, consult one of the independent agents who represent Princeton or call us at 1-800-433-0157.



Princeton Insurance Company

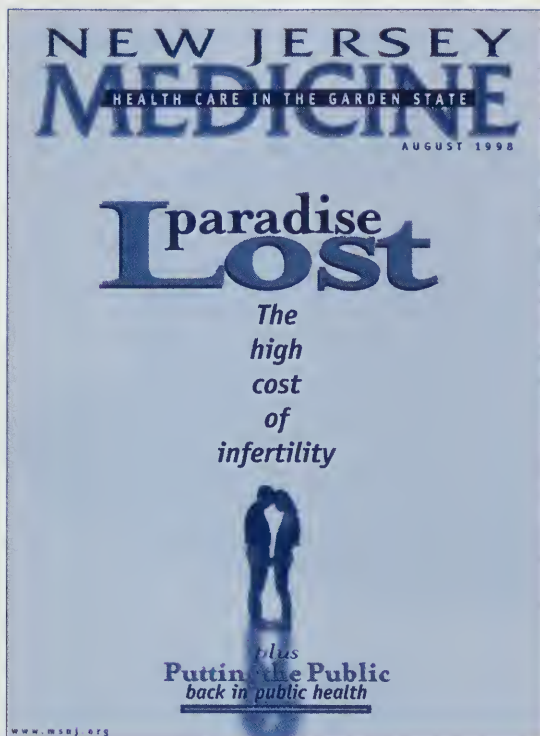
Professional Liability

Office Package Policy

Workers Compensation

Rated A- (Excellent) by A.M. Best Company 746 Alexander Road • Princeton, New Jersey 08540

FERTILE MINDS.



Inseminate your marketing challenges with the creative flair and results-generating strategies of Three Bears. We get it "just right" for New Jersey Medicine magazine, and we welcome the opportunity to help your business go forth and multiply.



THREE BEARS

ADVERTISING • MARKETING COMMUNICATIONS

20 NASSAU STREET, PRINCETON, NJ 08542
609-688-1400

NEW JERSEY MEDICINE

AUGUST 1998

Editor-in-Chief **Howard D. Slobodien, MD**
Executive Editor **Geraldine R. Hutner, MA**
Assistant Editor **Nancy M. Propsner, BA**
Editorial Assistant **Karen Cuzzo, BS**
Advertising **Cookson Media Services**
Production **Trenttypo, Inc.**
Graphic Design **Three Bears Communications**
Cover Photo **Conrad Gloos**

President and Chair **R. Gregory Sachs, MD**
President-Elect **Irving P. Ratner, MD**
First Vice-President **Walter J. Kahn, MD**
Second Vice-President **Angelo S. Agro, MD**
Secretary **Bessie M. Sullivan, MD**
Treasurer **Eileen M. Moynihan, MD**
Immediate Past-President **Carl Restivo, Jr, MD**

MEDICAL SOCIETY OF NEW JERSEY BOARD OF TRUSTEES

S. Manzoor Abidi, MD
Stevan Adler, MD
Churchill L. Blakey, MD
Donald J. Cinotti, MD
Rajendra Prasad Gupta, MD
George T. Hare, MD
David A. Ingis, MD
Philip J. Jasper, MD
Elliot M. Kraus, MD
Giovanni Lima, MD
Mark T. Olesnick, MD
Robert S. Rigolosi, MD
Andrew Kunish, MD, *Speaker of the House*
John W. Spurlock, MD, *Vice-Speaker of the House*
Francis J. Lumia, MD, *OMSS*
Jamsheed K. Najmi, MD, *Medical Specialty Societies*
Sean C. Reinhardt, *Medical Student*
Niranjan V. Rao, MD, *Member-at-Large*
Michael J. Spedick, MD, *Member-at-Large*
Valerie Claps, *MSNJ Alliance*
Carlo Porcaro, MD, *IMG Section*

COUNCIL ON COMMUNICATIONS

Charles M. Moss, MD, Chair, Harry M. Carnes, MD, Vice-chair.
Henry R. Liss, MD, Vice-chair, Richard M. Ball, MD,
John P. Capelli, MD, Paul J. Carniol, MD,
Andrew B. Covit, MD, Anthony Del Gaizo, MD,
Joseph A. Di Lallo, MD, Michael J. Doyle, MD,
Leigh Ende, MD, Steven C. Fiske, MD,
Jack Goldberg, MD, Daniel P. Greenfield, MD, MPH,
George H. Hansen, MD, M. Arif Hashmi, MD,
Christine E. Haycock, MD, Neil B. Horner, MD,
Monroe S. Karetzky, MD, Ismail Kazem, MD,
Louis L. Keeler, MD, Scott P. Keil, MD,
Joseph W. Kozielski, MD, Clement H. Kreider, Jr, MD,
Alan J. Lippman, MD, Robert M. MacMillan, MD,
George J. Mellendick, MD, MPH, Donald W. Orth, MD,
Robert M. Pallay, MD, Sindy M. Paul, MD,
Arthur W. Perry, MD, Niranjan V. Rao, MD,
Kelly M. Reid, MD, Carl Restivo, Jr, MD,
John D. Slade, MD, Leon G. Smith, MD,
Julie E.K. Timins, MD, Sandra S. Valdez, MD,
Paul E. Wallner, DO, Richard A. Williams, MD

Our medical specialists make a practice of creating solutions for physicians like you.

Summit Bank's Healthcare Financial Services Group features some of the finest medical specialists in New Jersey. They understand your industry and the issues facing it. As New Jersey's largest locally headquartered bank, our professionals are specifically devoted to the healthcare industry. That means our customized solutions — from loans to leases — come with something extra: time-tested expertise. If you'd like, we'll even help you find a more efficient way to run your practice. To find out more, call Norm Buttaci, Regional Vice President, 609-987-3561.



Summit, Summit Bancorp and Reach Higher are registered service marks of Summit Bancorp • Summit Bank is a service mark of Summit Bancorp.

22

Focus on health care

Paradise lost: The high cost of infertility

By Bill Berlin, PhD

The rights of fertility have given way to an array of scientific procedures that compensate for or correct what nature has not provided. Who pays?

27

Law, medicine, & ethics

New regulation for prescriptions

By Steven I. Kern, Esq; Denise L. Sanders, Esq

Physicians who write prescriptions must comply with a new state Board of Medical Examiners regulation or face severe penalties.

33

Clinical report

Epilepsy in pregnancy

By Claudine Sylvester, MD; James L. Breen, MD

Women with epilepsy have higher complication rates during pregnancy, labor, and delivery. Special treatment must be considered.



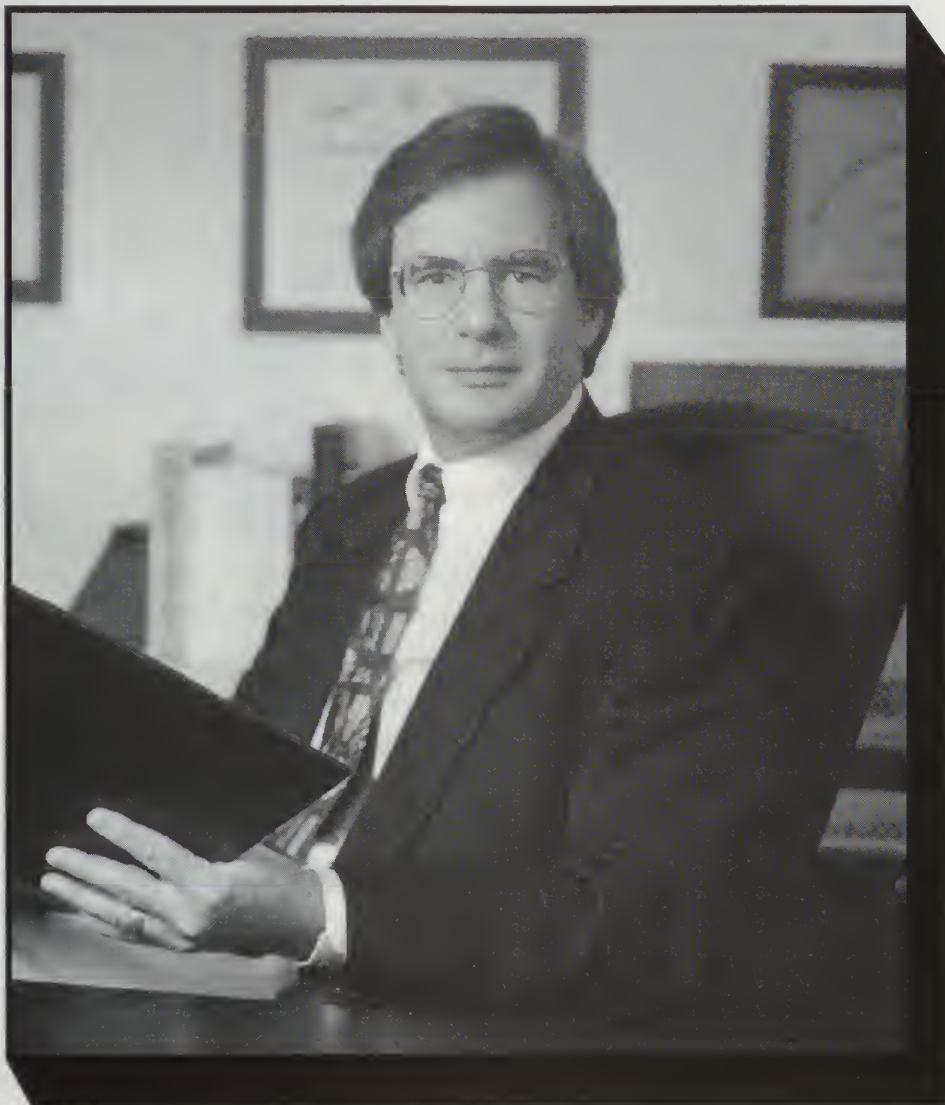
*David Canavan on
physician health.*



*Paul Bergh on
infertility costs.*



*Lucy Forgione
on public health.*



Stuart M. Hochron, M.D., Esq.

Physician Legal Representation

- Group Practice Formation
- Physician Litigation
- Federal Regulation
- Board of Medical Examiners

Practicing Physician, Twenty Years
Clinical Professor, UMDNJ-RWJMS
Research as Highlighted on CNN
AMA Physician Referral Service
Partner, Richmond, Hochron & Burns



phone: (732) 821-0200 fax: (732) 422-9444 e-mail: MDLAWSMH@aol.com

209 North Center Drive North Brunswick, New Jersey 08902

41 Computer.med

Computers as consultants

By Eric Lerner

Computers encode the knowledge of specialists and make this available in the form of advice on treatment. What role will computers play in patient care?

45 Health policy

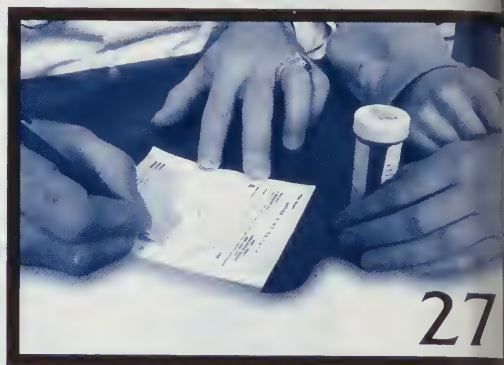
Putting the public back in public health

By Michael Greenberg, PhD; Dona Schneider, PhD, MPH; Latoya Duncan; Jamie Moskowitz
Local health officers feel the health of their communities are in jeopardy, especially in areas where the population is disadvantaged.

56 MSNJ news

In memoriam

We pay tribute to and remember fellow members of the Medical Society of New Jersey.



27

Writing prescriptions? You must comply with a new state Board of Medical Examiners regulation.



45

Local health officers feel we need to put the public back in public health.

DEPARTMENTS

1 Newswatch

Acting locally. HMOs defend turf. Network role evolves. Physician practices.

10 Mail Stop

Golden Merit honoree; MSNJ's Physicians' Health Program helps physicians. Malpractice damages.

15 Editor's Notes

It's more than herbs. Just what is alternative and complementary medicine?

18 Online @ MSNJ

Advice from the experts. Millennium bug. New vision of publishing.

54 Calendar

Current listing of medical meetings and conferences around the state in the fall.

61 F.Y.I.

Who will be the Person of the Year? Whitman honors health care professionals. Vaccination update.

63 Person of the Year

Who is effecting change in the health care community in the Garden State?

64 Photo Finish

The primary care nurse—responsible for coordinating hospital care—offers support to all patients.

Medical Society of New Jersey

Long Term Care Insurance Program

Ensuring a Secure Future by Preserving Assets

As medical professionals, you know first hand the devastating effects that extended long term care can have on a person's hard earned assets. The cost of nursing home stays can range from \$3,000-\$5,000 per month. The Medical Society of New Jersey endorses The Travelers and CNA Insurance Companies' policies to help you guard against unforeseen tragedies. Through a special arrangement with The Travelers and CNA Insurance Companies, members, spouses, parents and in-laws are eligible for a premium reduction.

IMPORTANT FEATURES OF THE MSNJ ENDORSED LONG TERM CARE INSURANCE PROGRAM

- ◆ Available Ages 45-84
- ◆ Specialty Plans Available Ages 80-100
- ◆ Benefits up to \$250/day
- ◆ No prior hospitalization required
- ◆ Several waiting periods
- ◆ Alzheimer's, senility covered
- ◆ Lifetime benefits available
- ◆ Guaranteed renewable for life
- ◆ Coverage for custodial, skilled and intermediate care as well as adult day care
- ◆ Available to your spouse, parents and in-laws
- ◆ Waiver of premium benefit
- ◆ Inflation protection available

DISCOUNT FOR MEMBERS OF MSNJ, SPOUSES, PARENTS AND IN-LAWS

For more information, please call

DONALD F. SMITH & ASSOCIATES

A division of THE COPELAND COMPANIES*

Two Tower Center, P.O. Box 1063
East Brunswick, New Jersey 08816-1063

(888) 297-7225

Copeland Associates, Inc.

Medical Society of New Jersey
MSNJ

Golden Merit honoree

Thank you for your kind words on the death of my husband, Herbert Langer, MD. My family and I will treasure the Golden Merit plaque and pass it down from generation to generation as a tribute to father and grandfather.

Herbert Langer, MD, was a dedicated, warm, and empathetic doctor who enjoyed his profession and had the loyalty and respect of his patients for over 45 years in private practice as well as the five years in residency and in the Air Force as an obstetrician-gynecologist.

Dr. Langer was always interested in MSNJ and attended meetings until his illness; he enjoyed the men and women of MSNJ and looked forward enthusiastically toward occasions when he could meet with all of you.

*Beatrice Langer
Westfield*

Physician health

The Physician's Health Committee of the New Jersey Psychiatric Association appeals to all physicians in New Jersey to rise above the stigma of impairment along with the fear of risking repercussions from the state Board of Medical Examiners (BME) by taking better care of themselves. The Physicians' Health Program of the Medical Society of New Jersey succeeds in keeping the commitment of confidentiality. To enter the Alternative Resolutions Program (ARP) referred to on page 5 of the biennial renewal applica-

tion for your medical license in New Jersey, just call the office of David I. Canavan, MD, at MSNJ, 609.896.1766.

The wording in the license renewal application is somewhat intimidating: "The licensee must be accepted by the Impairment Review Committee and assigned a code number." We believe this, along with all of the questions on page 5, actually discourage those who most need and want help from actually getting this help. We have strongly urged BME to omit such questions and we have appealed to the commissioner of health and the governor's office. We are greatly dismayed that such questions remain, but we wish to advise that our appeals of 1995-1996 did not go totally unnoticed. The ARP has been set up. Careful re-reading of your biennial renewal questionnaire will reveal that, theoretically, you could have a substance abuse problem or psychiatric illness, but as long as you are in the ARP, you need reveal nothing when you renew your license. Our

*David Canavan, MD, medical director,
MSNJ Physicians' Health Program*



careful discussion with Dr. Canavan and his committee insures us that a simple telephone call on your part will free you from the need to lie on your license renewal. We still object to the stigma factor, but we are addressing that in many ways; right now we are addressing that issue by this communication with you, the physicians of New Jersey. We intend to continue to appeal to BME for the following reasons:

We object to the stigma of singling out applicants on the basis of psychiatric illness, which organized psychiatry has fought so hard to reduce.

We object to the strong disincentive such questions provide to any physicians seeking psychiatric treatment; inevitably many health care providers with potentially treatable disorders will avoid treatment, leaving the public at greater risk, which purpose can be achieved better through review of the applicant's performance and character. Anyone applying for license or license renewal has undergone rigorous training and close supervision, which give ample opportunity to detect impairments or severe character flaws. Problems arising later can best be handled by ourselves; not by the asking of such questions. Furthermore, we fear the potential disincentive such questions provide to the psychiatrist seeking psychoanalytic training, which includes a personal analysis.

We believe these questions are in violation of the Americans with Disabilities Act (ADA). Indeed the

Lowest Premiums for Quality Malpractice Insurance

Th Joseph A. Britton Agency can help make it happen. If you are a preferred risk¹, you can qualify for preferred rates². Compare these annual premiums at occurrence limits of \$1,000,000/\$3,000,000:

• Anesthesiologists	\$ 8,572
• General Surgeons	\$18,453
• Internists	\$ 5,331
• Ob-Gyns	\$39,000
• Radiologists	\$ 5,331
• Plastic Surgeons	\$23,350
• Psychiatrists w/ect	\$ 2,937
• Urologists	\$11,993

With more than 25 years of experience, the Britton Agency has proven exceptional in packaging malpractice insurance. Our professional staff and size assure you the benefits of specialized, personal service while offering you insurance at the lowest cost.

Call for a free consultation. Start saving tomorrow.



Joseph A. Britton Agency, Inc.

Healthcare & Professional Liability Insurance
855 Mountain Avenue, Mountainside, NJ 07092
(908)654-6464 • Fax: (908)654-1422 • 1(800)462-3401

¹Underwriting approval required.

²May need groups of 3 or more depending on specialty.

DIAL THIS ONE NUMBER FOR INTENSIVE OFFICE CARE



973-763-7394

TOTAL OFFICE SET-UPS
REORGANIZING OF YOUR OFFICE
HIRING & TRAINING OF PERSONNEL
SELLING OF PRACTICES
FEE SCHEDULE UPDATES
BILLING & COLLECTIONS
ICD & CPT CODING UPDATES

MARY ANN HAMBURGER
A S S O C I A T E S

Office management not handled efficiently, can be the most stressful part of your practice. Let us handle it for you.

CD Investors:

HIGH INCOME WITH LIQUIDITY

**100% NO
LOAD**

Prime Reserve Fund

Current 7-Day Yield[†]

5.00%

T. Rowe Price Prime Reserve Fund is a money market fund that offers you:

- Potentially higher returns than bank money market deposit accounts
- No withdrawal penalties—unlike bank CDs
- A sensible holding account for cash between investments

High income, low risk. Prime Reserve invests primarily in money market securities—U.S. government and foreign and domestic bank obligations—with the *highest credit ratings*. Short-term maturity, credit quality, and our intensive analysis help lower risk and generate potentially higher yields than bank money market deposit accounts. Unlike bank products, the fund does not offer a fixed rate of return and is neither insured nor guaranteed by the U.S. government.

Stability. The fund has maintained a stable \$1 share price* since its inception 21 years ago.

Minimum investment \$2,500. Free check-writing.** 100% no load.

Call 24 hours for your free investment kit including a prospectus

1-800-541-4794

www.troweprice.com

Invest With Confidence®
T.RowePrice

[†]Simple yield as of 7/2/98. Past performance cannot guarantee future results.

*There is no assurance the fund will be able to maintain the \$1 share price.

**\$500 minimum. Read the prospectus carefully before investing.

T. Rowe Price Investment Services, Inc., Distributor.

PRF043367

ADA was designed with the specific intent that hiring and credentialing should be based on ability, performance, and character, and not on the fact of past treatment or impairment.

We believe these questions focus undue attention on treatment and past personal issues such as stress at the time of divorce, at death, or in the family. This kind of information need not be given to BME. We have anecdotal evidence that the results of such questions cause undue stress to physicians who are of no danger to the public. Furthermore, we believe this questionnaire discourages physicians from continuing their treatment. We do not fear "leaks" in the confidentiality commitment of Dr. Canavan and his committee, but we surely can understand how a physician might after reading this questionnaire.

Nevertheless, we urge that you take care of yourself and if that includes making that telephone call, do it! Re-read the questions. You cannot be unjustly denied your license if you are in the ARP. Meanwhile, we are working to remove those stigmatizing questions for all the right reasons mentioned. However, if you are substance abusing or acting out in front of colleagues and/or patients, no one can promise that you will escape the BME. You could lose your license. Do not do that. Make that call. You worked too hard to become a licensed physician.

A recovering physician

Malpractice damages

The malpractice crisis seems to have abated, and most physicians have more urgent concerns about their practices in the context of the changing health delivery scene, but the cost of malpractice insurance and the threat of being sued continue to occupy a significant place in how most practices are run. For those who have been or are actual defendants, the experience ranges from troubling to devastating.

Damages by Barry Werth (Simon & Schuster, 1998) is a moving personal story that deals with facets of malpractice suits rarely explored in public. Werth, a science journalist, recounts in detail the history of a single malpractice case in its eight-year long course in the 1980s and 1990s. The emphasis is on how the proceedings profoundly affected the lives of everyone involved: the plaintiffs, parents of a boy with cerebral palsy who claimed that his severe problems resulted from poor prenatal and delivery room care; the accused obstetrician and her community hospital; the numerous attorneys on both sides who strug-

gled to formulate their cases, carefully weighed the tactical advantages and disadvantages of every turn of events and sometimes developed elaborate justifications for their actions; and the many physician expert witnesses who submitted their opinions and testified.

If the reader can maintain some distance from the protagonists, the book is an engrossing drama that propels one to read, rapidly through the pages to discover each new development and learn what the denouement will be. Werth has a vigorous style that occasionally becomes flowery and unbelievable. For example, in an account of a deposition, he describes a lawyer reacting to a question. "The strangeness of the question [to a witness] nearly launched Doyle from his seat." Elsewhere he characterizes one expert witness as "a lavish host who likes to provide steaks and drinks at depositions and who invited the legal staff 'to climb into [his] gold Mercedes to drive to his rambling stockbroker [home] on Summit's posh north side.'" Werth tends to favor the legal viewpoints on issues; if fact, in his final pages, he explicitly endorses the plaintiff attorney's analysis of what happened, although the facts are clearly open to differing interpretations. Nevertheless, *Damages* is an invaluable description of the personal consequences of a malpractice case and is highly recommended to physicians interested in medical legal affairs.

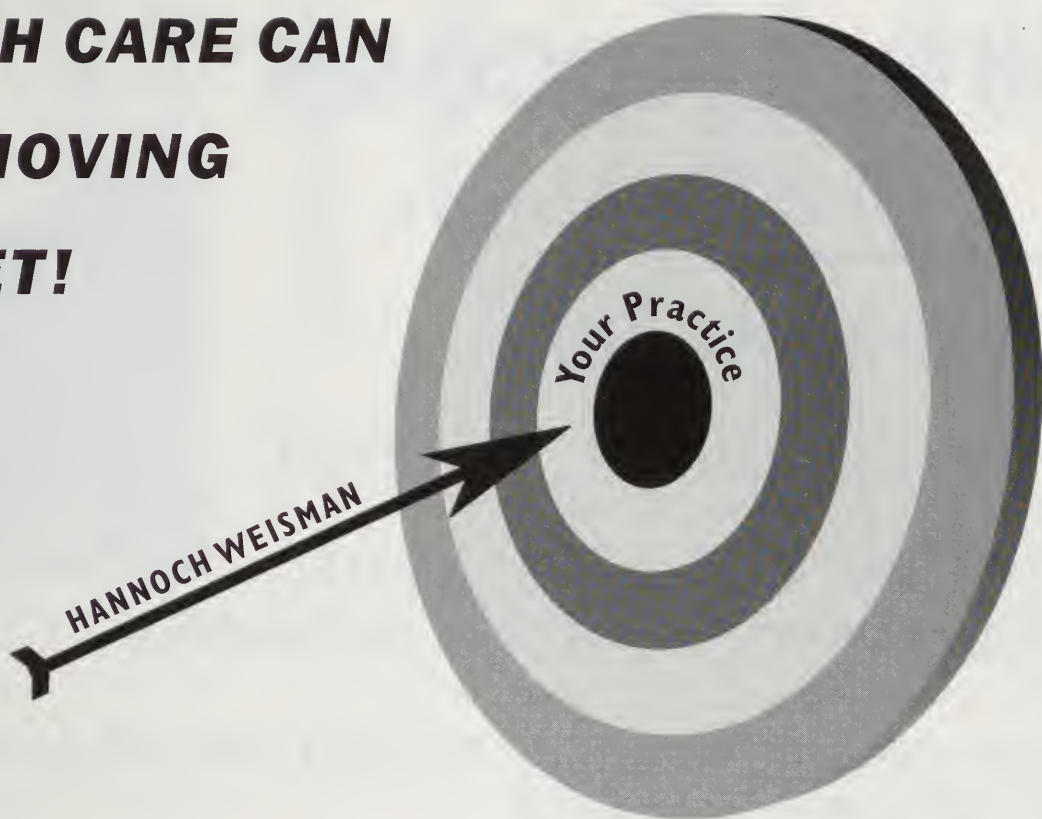
Norman J. Sissman, MD
New Brunswick

Requirements for letters

To submit a letter, fax (609.896.1368), e-mail (info@MSNJ.org), or mail your letter to New Jersey Medicine, Two Princess Road, Lawrenceville NJ 08648. Letters should be typed and double-spaced and should be no longer than 400 words with 4 references, if necessary. Include your full name, affiliation, address, and telephone number.

Letters are published at the discretion of the editor-in-chief and are subject to editing and abridgement. Letters may be published on MSNJ's web site, <http://www.msnj.org>. Financial associations or other possible conflicts of interest must be disclosed. Letters represent the opinions of the authors.

HEALTH CARE CAN BE A MOVING TARGET!



WHEN YOU CAN'T AFFORD TO MISS . . .

HANNOCH WEISMAN HAS A RECORD OF HITTING THE MARK WHEN ADVISING PHYSICIANS ON:

- ✓ Practice formation, management and operations
- ✓ Review and negotiation of managed care contracts
- ✓ Corporate transactions including mergers and acquisitions and joint ventures
- ✓ Licensing, peer review and disciplinary matters
- ✓ Professional liability and risk management
- ✓ Governmental and payor inquiries and investigations
- ✓ Medical staff relations and credentialing
- ✓ Employee relations and benefits

For assistance or information contact
Lisa D. Taylor, Esq.
James J. Shrager, Esq.


HANNOCH WEISMAN

A Professional Corporation, Counsellors at Law
4 Becker Farm Road, Roseland NJ 07068
973-535-5300

Direct AccessSM

for small employers

- Visit a specialist
without a referral.

- Nationwide access to over 300,000 participating doctors, specialists and hospitals.

- Value added discounts for you and your employees from Cole Vision and CompUSA.



And, announcing a \$25,000 *life insurance program* for small employer groups that join the MSNJ/BCBSNJ program!

This and more is available when you choose the new Direct Access health plan from Blue Cross and Blue Shield New Jersey—The Medical Society of New Jersey's health carrier of choice for its members!



**BlueCross BlueShield
of New Jersey**



Ask us for a free
copy of the SEH
Buyer's Guide.

For more information on Direct Access, and other
health plans for individuals, families
and small employers,

contact the Medical Society of New Jersey's
exclusive BCBSNJ representative:



Jennifer Altobelli
Sales Representative
973-338-0893

It's more than herbs, Herb.

At the June meeting of the MSNJ Council on Communications, a surprising number of physicians suggested an article or a series of articles on alternative and complementary medicine. Many of the advocates were from northern New Jersey, and, by coincidence, that day's *Bergen Record* had a special article on complementary/alternative medicine in Bergen, Hudson and Morris Counties. Various hospitals were listed as having programs in alternative and holistic medicine, Tai Ji Quan, chiropractic, yoga, and mind/body coping.

Some of you also may have seen the recent article about the cardiac valve operation performed at Columbia-Presbyterian Medical Center by the head of that institution's Complementary Care Center. Preoperative hypnosis and intraoperative soothing music were expected to alleviate anxiety and provide a smoother postoperative course. Other patients might expect to receive yoga classes, massage, touch therapy, aromatherapy, or energy healing.

In December 1996, my editorial, "That's an herb, Herb," cited an A to Z list of methods pro-

posed for treating cancer, and indicated the confusion differentiating conventional, alternative, and "natural" treatments. It also mentioned the establishment of the Office of Alternative Medicine (OAM) in the National Institutes of Health (NIH), and the involvement of insurers and of medical schools. It dealt mainly with herbal usage, but it emphasized caveat emptor.

Bill Berlin wrote on the same subject in the April 1997 issue of

New Jersey Medicine. He added to the list of institutions investigating "other" treatments, noting that the OAM had funded 52 studies. He also warned against blind acceptance and emphasized the need to know. Berlin surmised that some of the attraction of these methods related to interpersonal relationships between practitioner and patient.

This is big business. Every day sees advertisements and articles,

some laudatory, some disproving, and some censorial. *Nutrition Action*, published by The Center for Science in the Public Interest, has recently condemned DHEA (we have, too), and cautioned about using Cholestin and other Asian botanicals, phytosterols, garlic, glucosamine and chondroitin, echinacea, ginkgo, and others.

Worst Pills, Best Pills, published by Sidney M. Wolfe's Public Citizen's Health Research Group, is hypercritical. It points out the potentially lethal effects of Chomper, an herbal laxative that can be contaminated with digitalis. Digitalis, also found in plantain, has been used in some specialty teas. (This is not the tropical fruit of the same name.) Ji Bu Huan, used as a sedative and pain killer, has exhibited liver toxicity. Melatonin, also a

Howard D. Slobodien, MD



**What man wants is simply
independent choice, whatever
that independence may cost and
wherever it may lead.**

**Feodor Dostoevsky, *Notes from
the Underground*, 1864**

Editor's Notes

recent favorite, has produced seizures in children.

Many of the current difficulties in ascertaining the true qualities of these products are compounded by the 1994 Dietary Supplement Health Education Act, sponsored by Senator Orrin Hatch (R, Utah). This legislation removed herbal and dietary supplements from regulatory inspection, leaving it up to consumers or other independent groups to fend for themselves. Even Germany, which does not usually require clinical trials of these products, has established standards for purity and effectiveness.

But it's not just herbals. And how do we educate ourselves? Our most promising source(s) of information can be found on the Internet. Many search engines lead to thousands of references—probably more than one can absorb—but the information is there for the taking.

The OAM, for example, enters the following alternative medicine web sites: acupuncture, Alexander technique, aromatherapy, Ayurvedic medicine, complementary cancer therapies, gemstones, herbology, holistic medicine resources, homeopathy, iridology, macrobiotics, massage therapies, meditation, mind/body medicine, naturopathic medicine, Qi Gong, Tai Chi, and yoga. (We should note the November 1997 NIH acceptance of acupuncture as "an effective treatment for certain conditions," and the two new CPT acupuncture codes the AMA added this year.)

The Alternative and Complementary Medicine Center lists the

**Alternatives, and
particularly desirable
alternatives,
grow only on
imaginary trees.**

Saul Bellow, *Dangling Man*, 1944

"systems of medicine designated by the World Health Organization as traditional medicine," but usually considered alternative or complementary in the United States, as: acupuncture, Ayurvedic medicine, chiropractic, herbal medicine, naturopathic medicine, osteopathy(!), and traditional Chinese medicine. This Center also records the following as alternative and complementary therapies: aromatherapy, biofeedback training, bodywork, and somatic therapies, chelation therapy, detoxification therapies, energy medicine/bioenergetic medicine, environmental medicine, expressive arts therapies, fasting, flower remedies, guided imagery, integrative dentistry, mind/body medicine, nutritional (orthomolecular) medicine, and Oigong (Chi Kung) and Taiji (Tai Chi). Interesting compilation, nicht wahr?

But why do so many opt for alternative treatments, as a substitute for traditional ones, or for complementary systems, as an adjunct? Some patients with chronic benign illnesses not amenable to cure by conventional means, and some

patients with life-shortening diseases will grasp at anything that may help. Many people, dissatisfied with traditional treatment, are looking for less expensive, less impersonal care to give them greater satisfaction and increased self-determination. Others may be looking for nirvana.

Although perhaps only about 5 percent of people use alternative medicine exclusively, as many as 50 percent of some populations include alternative or complementary methods. This is not surprising because most illnesses are diagnosed and treated by patients themselves, and most are benign and self-limiting. Hence, we should insist that the effectiveness and the safety of these preparations, systems, and devices be evaluated as carefully, yet as expeditiously, as possible. We should not automatically disparage nor accept the use of alternative and complementary methods, but keep open minds while awaiting clear-cut evidence. We should become familiar with the basics, and the Internet is a prime source. We should also avoid the biased reportage of *JAMA* and *The New England Journal of Medicine*, criticized so severely in *The New York Times Magazine* of June 28, 1998.

Many questions need answering. Should the Hatch bill be repealed? How much power should be given the Food and Drug Administration? Should herbalists and other practitioners of nontraditional medicine have training and practice requirements? Additional articles are planned. I welcome your comments and your manuscripts. Meanwhile, happy browsing.

Critical Treatment for the Future of Your Practice...



Before It's Too Late

Wilentz, Goldman & Spitzer's Health Care Law Practice Group serves health care professionals regarding: group practice formation and operations; management service organizations (MSOs); physician practice management companies (PPMCs); managed care contracting; physician-hospital organizations (PHOs); independent

physician associations (IPAs); restrictive covenants; and regulatory, employment, tax and litigation matters. **Think of us as preventive medicine for your practice.** For information please call our Health Care Law Practice Group Co-Chairs: Michael F. Schaff at (732) 855-6047 or Francis V. Bonello at (732) 389-5636.

**WILENTZ
GOLDMAN
& SPITZER**
ATTORNEYS AT LAW

"Helping The Health Care Professional"

Woodbridge, NJ • Eatontown, NJ • New York, NY

<http://www.newjerseylaw.com>

ADVICE FROM THE EXPERTS

Have a medical or health-related question? Ask the experts at MSNJ—online, of course. Health care consumers can get up-to-the-minute medical information by MSNJ physicians, dedicated to a healthy New Jersey.

Go to "Ask the Doctor" on MSNJ's web site (www.msnj.org) to ask a question, read answers to other people's questions, or find out about the latest public health alerts. Physicians, suggests Charles M. Moss, MD, chair of the MSNJ Council on Communications, can use this newest feature to enhance physician-patient communications by recommending "Ask the Doctor"—and other appropriate consumer medical web sites—to their patients.



Charles M. Moss, MD

MILLENNIUM BUG

The year 2000 computer problem is no laughing matter. Don't ignore it. Get help now. That's what all the experts are saying. Computer applications that are not year 2000 compliant are headed for trouble. Applications using a 2-digit character field for the date function, where 98 reads as 1998 and 99 as 1999, will read 00 as 1900, instead of 2000, causing an explosion of problems.

TASK FORCE 2000 (www.technologynj.org) recently brought together public and private sectors to discuss, share, and promote solutions. And keep in mind legal aspects that may arise later, if steps aren't taken now to remedy the problem, advises the law firm Hannoch Weisman, in Roseland.

A NEW VISION OF PUBLISHING

Internet and computer technology is slowly working its way into the book publishing industry. Now, with digital printing, traditional pre-press processes have been abandoned. Many authors self-publish online. Plus everyone knows the company, Amazon.com, with its well-established online book distribution. Hot on its heels are innovative companies like Trenton-based Xlibris Corp. (www.Xlibris.com or 1.888.7XLIBRIS) that provides author services and prints books as they're ordered—with a single copy cost that's comparable to bookstores. With this method there's no extra copies that were printed but never sold and books don't go out of

print, since they're stored in a permanent digital archive. Xlibris entrepreneurs John Feldcamp and



Christopher B. Kelly think they're on the crest of the wave of the future.

BOOKMARKS

www.healthfinder.gov

Healthfinder is your gateway to online consumer health information produced by the federal government and its many partners.

www.bioview.com

Looking for a job just got easier. Career opportunities and late-breaking news in the biotechnology, pharmaceutical, and medical device and diagnostics industries.

www.pseg.com

To three-fourths of New Jerseyans, PSE&G is a household name. Go online to find out about PSE&G's new "worry free" service contract.

www.netgrocer.com

Never wheel a grocery cart down the aisle again. Instead, click on the first nationwide online supermarket, offering thousands of brand name items up to 20 percent less than supermarket prices.

www.fda.gov/opacom/catalog/vaccine.html

Even many health care professionals find vaccinations confusing. Get straight answers from the Food and Drug Administration site.

LIFSHUTZ, POLLAND & ASSOCIATES, P.C.

THE LAW FIRM THAT SPECIALIZES IN HEALTH CARE REPRESENTATION OF PHYSICIANS AND OTHER HEALTH CARE PROFESSIONALS.

OUR AREAS OF EXPERTISE INCLUDE:

1. Managed Care Contracts with MSOs and HMOs.
2. Health Care Mergers/Joint Ventures/Acquisitions.
3. Development and implementation of Compliance Audits and Plans.
4. Representations in Board of Medical Examiner Cases.
5. Asset Protection/Estate Planning as protection against malpractice suits.
6. Federal and State Anti-Kickbacks/Stark/Safe Harbor representation.
7. Medicare/Medicaid/Third Part Audits

OUR EXPERT STAFF CONSISTS OF SPECIALIZED ATTORNEYS AS WELL AS PHYSICIAN-ATTORNEYS.

LIFSHUTZ, POLLAND & ASSOCIATES, P.C. ATTORNEYS AT LAW

363 LAFAYETTE AVE., HAWTHORNE, NJ 07506
(201) 427-2040

175 FIFTH AVENUE, NEW YORK, NY 10017
(212) 949-8484

Web: Lifshutz-Polland.com

The Medical Manager[®]

Practice Management Software

A fully integrated practice management solution

Over 16 years' experience in providing healthcare automation solutions

Provides an open system architecture and flexibility for specialized needs

Designed for small group practices to large Integrated Delivery Systems

Overwhelming national presence

Learn more about how Medical Manager Corporation and The Medical Manager system can meet your needs. Contact us at 800.677.7784, 201.808.0088, or www.medicalmanager.com.

Medical Manager

Corporation

RTI, Inc. and Medix

Empowering the Industry Through Partnership



Excel Business Park

501 Prospect Street

Unit 96

Lakewood, NJ 08701

Phone: 732-886-0600

Fax: 732-886-0911

"The overall effect is total customer satisfaction."

- Medical/Dental Cabinetry
- Nurses Stations
- Reception Desks
- Nourishment Centers
- Medical/Dental Procedure Carts
- Computer Desks
- Monitor Cabinets
- Chart Racks
- Corian[®] Solid Surfacing
Certified Fabricator #C-5112
- Space Planning/Layout



UNPRECEDENTED ACCOUNTABILITY
CONFLICTING PERFORMANCE CRITERIA
MULTIPLE, FRAGMENTED PROCESSES
TIME-CONSUMING
MORE DOCUMENTATION
LESS PATIENT CARE
HIGH COST
DUPLICATIVE OFFICE TIME REVIEWS
INCONSISTENT CREDENTIALING
NEVER-ENDING PAPERWORK
ADMINISTRATIVE HASSLES

Our solution has arrived.

One Time

One Source

One Standard



American
Medical
Accreditation
Program

With the new American Medical Accreditation Program (AMAP), physicians submit an application **ONE TIME**, have their credentials primary-source verified **ONE TIME**, and have an on-site office review **ONE TIME**.

AMAP then provides an Accreditation report and certificate to each physician who meets the AMAP national standard.

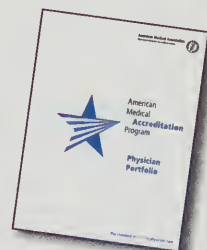
Next, AMAP will provide a complete portfolio of verified credentials, office site survey and other frequently requested information to each health plan and hospital that uses AMAP and with whom the physician is affiliated.

The American Medical Accreditation Program is a voluntary, comprehensive accreditation program that measures and evaluates individual physicians against national standards, criteria and peer performance in five areas: **Credentials, Personal Qualifications, Environment of Care, Clinical Performance, and Patient Care Results.**

Meeting and maintaining AMAP's high standard earns a physician AMAP Accreditation – a new national benchmark of physician quality.

AMAP, your one source for the new national standard of physician quality information, has arrived.

To learn more about the many benefits AMAP has to offer *your* organization, call the AMAP Resource Center at 1-888-881-AMAP (2627) or visit the AMAP Web site at <http://www.ama-assn.org>.



The standard in quality physician care.

American Medical Association
Physicians dedicated to the health of America



THE WISH TO BEAR CHILDREN IS A TIMELESS YEARNING. TODAY,
THE RIGHTS OF FERTILITY HAVE GIVEN WAY TO AN ARRAY OF SCIENTIFIC
PROCEDURES THAT AIM TO COMPENSATE FOR OR CORRECT WHAT NATURE
HAS NOT PROVIDED. BUT WHO'S GOING TO PAY?

paradise Lost

*The high
cost
of
infertility*

By Bill Berlin, PhD

Ancient peoples beseeched Astarte, Aphrodite, and other deities to assure fertility. Until the fifth century AD, the Romans celebrated the Festival of Lupercalia, during which young men sacrificed goats and dogs, and then scampered around the Palatine Hill hitting women with goat skins. Women who were fortunate enough to be struck supposedly were assured of bearing a child.

The wish to bear children is a timeless yearning. Traditional peoples typically believed that all of life and fertility were of a piece. Through prayers, incantations, dances, and drama, fertility rites might induce human and animal fecundity and

unlock the sources of regeneration in all of nature. Today, the rites of fertility have given way to an array of scientific procedures that aim to compensate or correct for what nature has not provided. Today, the gods and goddesses of fertility wear white lab coats.

Their clientele, both real and potential, is large. According to various estimates, between one in seven and one in ten couples in the United States experience problems with infertility, typically defined as one year of unprotected coitus without conception. Infertility cuts across socioeconomic and racial lines and, despite a widely held stereotype, is not



Worldwide, between 50 and 80 million people suffer from infertility. Many infertile couples never seek treatment.

Infertility Talk

ART Assisted reproductive technologies, which include several procedures that attempt to unite sperm and eggs and, thus, overcome barriers to natural fertilization.

ICSI Intracytoplasmic sperm injection, the injection of a single sperm directly into the egg; a micromanipulation procedure used when a man has a low sperm count or limited sperm motility.

IVF In vitro fertilization, a procedure that involves the removal of eggs from the ovaries, laboratory fertilization with sperm from a male partner, and return of the fertilized embryo to the uterus.

GIFT Gamete intrafallopian transfer, a laparoscopic procedure through which sperm and eggs are mixed and then inserted into the woman's fallopian tubes; before the procedure a woman must be stimulated by hormone therapy.

ZIFT Zygote intrafallopian transfer, a technique that involves fertilization of the egg in the laboratory followed by insertion of the embryo into the fallopian tubes; once again the woman must initially be stimulated by hormone therapy.

over-represented among white, middle-class women who have delayed childbirth.

Worldwide, between 50 and 80 million people suffer from infertility, with significant variations from region to region. Many infertile couples never seek medical treatment. A 1993 study of infertile women found that only 43 percent discussed the issue with their obstetrician/gynecologist, and only 21 percent were ever examined regarding the source of the problem. Sixty-five percent of infertile couples who opt for treatment go on to have a child.

Shame and guilt may deter some people from pursuing treatment, but cost clearly is an important fac-

tor. The rites of modern reproductive technology—with such bewildering acronyms as ZIFT, GIFT, IVF, and ICSI—are not readily available to everyone. "If you're poor, you have no shot," says Pamela Madsen, executive director of a group called RESOLVE of New York City. "If you're middle class, you become financially devastated the rest of your life."

Madsen is not only an advocate for but also is a former client of RESOLVE. Ten years ago, as a 24-year-old schoolteacher, she and her husband, a manager of computer systems, lived a solid, middle-class life. After four years of infertility treatments, their entire nest egg was gone, and they had accumulated substantial credit card debt.

Happily, the treatments were successful, but the Madsens now live with their two boys in a cramped, one-bedroom apartment in Brooklyn.

This story is fairly common. Beth Dugan, advocacy coordinator for RESOLVE of New Jersey, spent \$40,000 on infertility treatments before she was able to get pregnant. Many people turn to overseas pharmacies or scan the Internet in search of bargains on expensive fertility drugs.

And the situation may only get worse before it gets better. Earlier this year, St. Barnabas Medical Center announced that it was raising the price it would pay for donor eggs from \$2,500 to \$5,000. The rising bounty on donor eggs may push the cost of advanced infertility procedures, which currently ranges between \$8,000–10,000 per IVF treatment, even higher.

"Historically, women donated eggs out of humanitarian motives," says Assemblyman Neil Cohen. "Now it's

going to be a money maker." Paying premium prices for women's eggs may create other economic and ethical problems related to advertising, consumer fraud, and malpractice, along with controversies over ownership and control of embryos.

Cohen believes that the rise of market forces in eggs will shed a whole new public light on the issue of infertility coverage. He has reintroduced a bill in the New Jersey Legislature, A-1763, that would require insurance companies to

Paul Bergh, MD, director, Institute for Reproductive Medicine and Science



cover infertility treatments. Thirteen states, including New York, California, and Arkansas, require insurers to cover or offer to cover some form of infertility diagnosis and treatment. Two states, Massachusetts and Illinois, require coverage of in vitro fertilization, the most successful of the advanced reproductive procedures.



Paul Langevin, Jr., New Jersey Association of Health Plans

dated coverage might give the insurance companies sufficient leverage to drive down the costs of donor eggs. Also, numerous women now opt for such invasive procedures as tubal surgery because it is covered under many insurance plans, rather than less expensive fertility treatments, which are not insured.

To this point, most insurance companies have been moving in the opposite direction. A 1995 survey of employer-sponsored health plans found that fewer than one in four health plan sponsors with at least ten employees cover some form of infertility treatment. Only 19 percent of health maintenance organizations provide coverage for IVF.

In January 1998, Aetna, Inc. announced that it was dropping coverage of advanced fertility treatments, including IVF, in its U.S. Healthcare plans, leaving it as an option to the fully insured. As one of the few insurance companies offering coverage, Aetna claimed that it was bearing an undue burden of costs.

Those, like Beth Dugan, who are pressing for mandated insurance, see reproduction as a basic right and infertility as a disability or disease. "We see this as a major women's health issue," she says, "comparable to the length-of-stay maternity and mastectomy bills." Calling infertility a disorder of the reproductive system, national RESOLVE has gone to court to have it covered under the Americans with Disabilities Act.

The insurance industry argues that covering infertility would be too expensive and just another item in a growing list of onerous mandates. Paul Langevin, Jr., president of the New Jersey Association of Health Plans, says that the industry's opposition to both bills in the Legislature is primarily economic. "IVF can be offered as a rider to any plan, but it will be an expensive rider, costing about \$3.50 per patient per month," Langevin says. "We already operate under 15 mandates in New Jersey, and this would drive costs up even more."

Advocates for infertility coverage dispute this argument. Citing a report by the consulting firm of William M. Mercer, they argue that mandating infertility coverage would increase premiums by no more than \$3.14 per member per year, and that insurance may actually reduce current costs in other ways. For example, man-

Pamela Madsen believes that mandated insurance would reduce the pressure on many clinics to produce high "success rates," and consequently lessen the risk of multiple births. "People who are paying \$10,000 out-of-pocket, care about percentage point differences in success rates," she says. In turn, this encourages some clinics to transfer more eggs, thus driving up the rate of multiple births.

Many countries in Europe, where coverage for infertility treatment is far more generous, have placed legal limits on the number of eggs that can be transferred. Although the American Society for Reproductive Medicine has recommended limiting the number of transferred eggs, "the situation in the United States is pretty much a free for all," notes Paul Bergh, MD, director of the Institute for Reproductive Medicine and Science at St. Barnabas Medical Center.

Most infertility specialists agree that mandated insurance must include guidelines that will control costs and discourage multiple births. In addition to limiting the number of embryos transferred, excess embryos can be frozen through cryopreservation to be used, if necessary, in subsequent cycles. Accelerated treatment and referral to the right practitioner also can reduce and best satisfy the needs of the patients at the same time.

The Mercer report suggests that costs can be controlled by requiring patient copayments and by restricting the number of cycles or procedures covered. Some countries have established female age and family size guidelines in an effort to control utilization.

Assemblyman Cohen is rewriting his bill to include some guidelines and cost controls. In the upper house, Senators Robert Martin and Jack Sinagra have sponsored S-773, a weaker bill that would require insurance companies only to offer coverage for infertility diagnosis and treatment. Of course, even with the enactment of mandated insurance in every state, many people still will lack infertility coverage, including workers covered under federally self-insured plans, Medicaid recipients, and the countless Americans who have no health insurance coverage.

You didn't build your reputation just so your insurance company could destroy it.

How your insurance provider handles malpractice suits can have a critical impact on your future. Many insurance companies will make little effort to defend you against lawsuits, preferring instead to settle. In those cases, the claim becomes part of your resume forever, and may affect your future. As you know, it's common practice for managed care organizations to deny participation due to past malpractice claims, including out-of-court settlements.

Consider instead the comprehensive services of B.C. Szerlip. We offer 60 years of experience providing top-quality insurance services to physicians and surgeons. We represent only "A" rated insurance companies who provide superior legal defense. Almost 70% of lawsuits against our customers are dropped. Our expert legal defense team wins more than 80% of the remaining cases. So there's almost never a loss or settlement to put a dent in your hard-earned reputation.

Due to the loyalty of our customers, B.C. Szerlip has achieved unparalleled financial stability. No matter when a claim is filed, we'll be here to defend you.

To give you a taste of our full-service approach, we'd like to send you a fascinating booklet, *The Managed Care Survival Kit for Physicians*. To receive your own obligation-free copy, please call us at 800-684-0876.

BCSZERLIP INSURANCE AGENCY INC.

99 WOOD AVENUE SOUTH, PO BOX 217
ISELIN, NJ 08830-0217
800-684-0876 • 732-205-9800
FAX: 732-205-9496
E-MAIL: bcszerlip@aol.com

*Professional Insurance Services
for Health Care Providers*

Balancing Quality With the Bottom Line

Practicing medicine
= good

Practicing running
a business
≠ good

*Practice management and
practice efficiency solutions
from professionals with
hands-on experience*

WITHUM, SMITH & BROWN

Certified Public Accountants & Consultants

Health Services Department

100 Overlook Center

Princeton, NJ 08540

609-520-1188

<http://www.withum.com>

Offices in New Jersey and Pennsylvania



ATAC Accounting for Time,
Activity, and Cost

MEMBER NEXIA INTERNATIONAL
A WORLDWIDE NETWORK OF
INDEPENDENT ACCOUNTING FIRMS



NEW REGULATION FOR PRESCRIPTIONS

ANY PHYSICIAN WHO WRITES PRESCRIPTIONS OR ADMINISTERS OR DISPENSES MEDICATIONS MUST COMPLY WITH A NEW STATE BOARD OF MEDICAL EXAMINERS REGULATION. THIS NEW REGULATION, WHICH WENT INTO EFFECT IN NOVEMBER 1997, CREATED GREATER STANDARDS AND REQUIREMENTS THAT, IF NOT FOLLOWED, CAN LEAD TO DISCIPLINARY ACTION INCLUDING THE LOSS OF A MEDICAL LICENSE.

By Steven I. Kern, Esq; Denise L. Sanders, Esq

A new regulation, effective November 3, 1997, affects every physician who writes prescriptions or administers or dispenses drugs. Physicians' obligations, when writing a prescription, or dispensing drugs in the office, now are codified to include an affirmative obligation to conduct an examination or evaluation of the patient's condition before writing a prescription or dispensing a drug, and assurance that "appropriate followup is provided and that the effects of the drug are properly evaluated and integrated into the treatment plan for the patient." Even greater regulatory standards and requirements are created for the prescribing or

dispensing of drugs scheduled as "controlled dangerous substances." Failure to strictly adhere to these complex and highly specific requirements can lead to disciplinary action, including loss of a medical license. It also creates a new benchmark for plaintiffs' lawyers in malpractice actions.

The new regulation carries forward an obligation, rarely followed, but always at issue in disciplinary actions, that a practitioner include certain specific information on each written prescription. The information includes: the prescribing practitioner's full name, address, telephone number, and



proper academic degree or identification of professional practice for which licensed; the full name, age, and address of the patient; the date of issuance; the name, strength, and quantity of the drug prescribed; words, in addition to numbers, to indicate the drug quantity authorized if the prescription is for a schedule II controlled substance, for example: ten (10) Percodan®; or five (5) Ritalin® mg; the number of refills permitted or time limit for refills, or both; the handwritten original signature of the prescribing practitioner; an explicit indication, by initials placed next to "do not substitute," if it is the prescribing practitioner's intention that a specified brand name drug be dispensed; the prescribing practitioner's DEA number, if the drug is a controlled substance; and adequate instruction for the patient as to frequency (a direction of "p.r.n." or "if needed" alone may be used if appropriate).

WHEN PRESCRIBING

The regulation carries forward statutory requirements placed on physicians when writing a prescription, which include an obligation of a prescribing practitioner "to advise each patient by adequate notice, for example, by a sign or pamphlet in the waiting room of the office, that the patient may request the practitioner to substitute a generic drug for any brand name drug prescribed." Further, "each practition-

er shall use only written prescription blanks, which shall be imprinted with the words 'substitution permissible' and 'do not substitute,' with a space for the prescribing practitioner's initials next to the chosen option, and which shall not include preprinted information designed to discourage or prohibit substitution."

DISPENSING FROM THE OFFICE

Physicians who dispense medication from their offices (including those who provide free samples) are subject to stringent requirements, clearly intended to deter them from dispensing, rather than writing a prescription. Keep in mind that the state Board of Medical Examiners (BME) has broadly defined "drug" as meaning any article recognized in the official *U.S. Pharmacopoeia*, official *Homeopathic Pharmacopoeia of the U.S.*, or official *National Formulary*, or any supplement to those sources, including, but not limited to, a controlled substance, a prescription legend drug, an over-the-counter preparation, a vitamin or food supplement, or any compounded com-

DISPENSING IS THE
DISTRIBUTION OF DRUGS
FOR A PATIENT'S
PERSONAL USE
AND DOES NOT INCLUDE
CERTAIN IN-OFFICE
ADMINISTRATION
OF DRUGS.

bination of any of the above or transdermal patch or strip, intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease or medical condition in humans, or intended to affect the structure or function of the human body. At this writing, BME is considering a petition for rule making requesting deletion of vitamins and food supplements from the definition of "drug." For purposes of the new regulation, dispensing is defined as the distribution of drugs for the personal use of a patient and does not include the in-office administration of drugs by way of injection, vaccine, allergenic extract or nebulized preparation, or the provision of multiple dose vials of injectable medications.

Physicians who dispense drugs in the office are officially obligated: "to maintain those drugs in an area kept in an orderly and sanitary manner, and in accordance with standard pharmaceutical practice and manufacturer recommendations concerning storage conditions, including refrigeration, where necessary. A practitioner shall not maintain in inventory any drugs that are outdated, misbranded, deteriorated, adulterated, recalled, unlabeled, damaged, discontinued, or which previously were dispensed to a patient."

Physicians who dispense medication must adhere to these standards and face serious additional obstacles, as well. These include a requirement that the disposal of any drugs must comply with all local, state, and federal requirements and not pose a health hazard. In addition, all drugs dispensed must be recorded in the applicable patient record and must be recorded in a permanent, contemporaneous dispensing log. Drug samples that are not controlled substances and that are packaged and labeled by the manufacturer, however, currently need be recorded only in the patient record, not the dispensing log. With this one exception, the dispensing log must include, at a minimum, the full name of the patient, the complete name of each drug dispensed, the strength and quantity of the drug dispensed, instructions as to the frequency of use, the date of dispensing, and the identity of the dispensing practitioner, if more than one practitioner dispenses in the office.

Each different drug dispensed, in whatever dosage form, except manufacturer packaged and labeled samples, must be placed in a separate container with a safety closure cap (unless the patient requests otherwise), and include the full name of the patient, a list of the ingredients

**DISPENSED DRUGS MUST
BE PLACED IN SEPARATE
CONTAINERS NORMALLY
WITH SAFETY CLOSURE
CAPS, UNLESS THEY ARE
MANUFACTURER PACKED
AND LABELED SAMPLES.**

if the drug was compounded, not manufactured, the date of dispensing, and the identity of the dispensing practitioner. Whether prepackaged or not, a legible label must be provided, which includes the complete name of the drug dispensed, the strength and quantity of the drug dispensed, instructions as to the frequency of use, special precautions, as appropriate, and the expiration date of the drug.

The regulation (implementing state statutory requirements) prohibits a practitioner from charging any patient a fee for a drug packaged and labeled by a manufacturer as a sample, and for drugs, other than samples, the physician can charge a fee only sufficient "to allow for a recoupment of a portion of overhead and administrative costs," which fee shall not exceed the actual acquisition cost plus 10 percent. "Actual acquisition cost" means the cost actually incurred by the physician in acquiring a drug from a supplier and does not include any amounts charged by any entity in which the practitioner has a direct or

indirect financial or other beneficial interest.

Moreover, as required by statute, if any fee, at all, is charged for the medication, either directly or indirectly, no more than a seven-day supply of the drug may be dispensed, the patient must be advised as to the alternative availability of the drug outside of the practitioner's office, and the actual acquisition cost of the drug to the practitioner must be disclosed to the patient, in advance of purchase and on the bill. BME has reserved on the proposed provision that also would have prohibited the dispensing of a drug at a frequency greater than once every 60 days (intended to prevent sequential distributions for seven-day periods). The requirements set out in this paragraph do not apply if the office at which the dispensing occurs is ten or more miles from the nearest pharmacy, if the drug is dispensed pursuant to an oncological or AIDS protocol, if the drug is a salve, ointment, or drops, or if the drug is dispensed in, and directly related to, the services rendered to the patient at a hospital emergency room, a student health center, or a publicly subsidized community health center, family planning clinic, or prenatal clinic.

LIMITS ON CDS

Of great significance is the requirement that when prescribing, dispensing, or administering any controlled substance, a physician must "ensure that a patient's medical

history has been taken and physical examination accomplished, including an assessment of physical and psychological function, underlying or coexisting diseases or conditions, any history of substance abuse and the nature, frequency, and severity of any pain." In addition, the medical record must reflect: a recognized medical indication for the use of the controlled substance; the complete name of the controlled substance; the dosage, strength, and quantity of the controlled substance; and instruction as to frequency of use. A physician is prohibited from prescribing or otherwise authorizing schedule II controlled substances in a quantity calculated to exceed 120 dosage units or a 30-day supply, whichever is less.

PAIN MANAGEMENT

A physician may exceed the 120 dose, 30-day supply restriction if the physician is following a treatment plan "designed to achieve effective pain management, which has been tailored to the needs of a patient who is suffering pain from cancer, intractable pain, or terminal illness." In such cases, the treatment plan must state objectives by which treatment success is to be evaluated, such as pain relief and improved physical and psychological function, and shall indicate if any further diagnostic evaluations or other treatments are planned. The physician is obligated "to discuss the risks

and benefits of the use of controlled substances with the patient, guardian, or authorized representative."

More regulations apply when controlled substances are continuously prescribed for management of pain for three months or more. These restrictions do not seem to be limited to schedule II substances. They include requirements that the physician: shall review, at a minimum of every three months the course of treatment, any new information about the etiology of the pain and the patient's progress toward treatment objectives; shall remain alert to problems associated with physical and psychological dependence; and shall periodically make reasonable efforts, unless clinically contraindicated, to either stop the use of the controlled substance, decrease the dosage, try other drugs such as nonsteroidal anti-inflammatories, or treatment modalities in an effort to reduce the potential for abuse or the development of physical or psychological dependence.

**WHEN EXCEEDING
STANDARD DOSAGE LIMITS
THE PHYSICIAN IS
OBLIGATED TO DISCUSS
WITH THE PATIENT THE
RISKS AND BENEFITS
OF THE USE OF
SCHEDULE II CDS.**

Where treatment objectives are not being met the physician is obligated to assess the appropriateness of continued treatment with controlled substances or undertake a trial of other drugs or treatment modalities. In addition, an affirmative obligation exists to consider referring the patient for independent evaluation or treatment. The physician also is officially advised to remain alert to the possibility that the controlled substances may be misused or diverted—continuing the stigma currently attached to all chronic pain patients.

When controlled substances are prescribed for management of pain, records must include copies of evaluations and consultations, a record of treatment plan objectives, evidence of informed consent, any agreement with the patient, and periodic reviews conducted.

PROHIBITIONS

Additional stringent rules apply to the use of narcotic drugs intended for purposes of detoxification or maintenance treatment, the use of amphetamines and sympathomimetic amines, and the use of anabolic steroids in the treatment of patients. Physicians engaged in use of these drugs should consult *N.J.A.C. 13:35-7.7* and *7.8* for specific requirements.

Mr. Kern and Ms. Sanders are principals of Kern Augustine Conroy & Schoppmann, P.C.

Whether it's an alcohol or drug problem, count on Sunrise House for expert help.

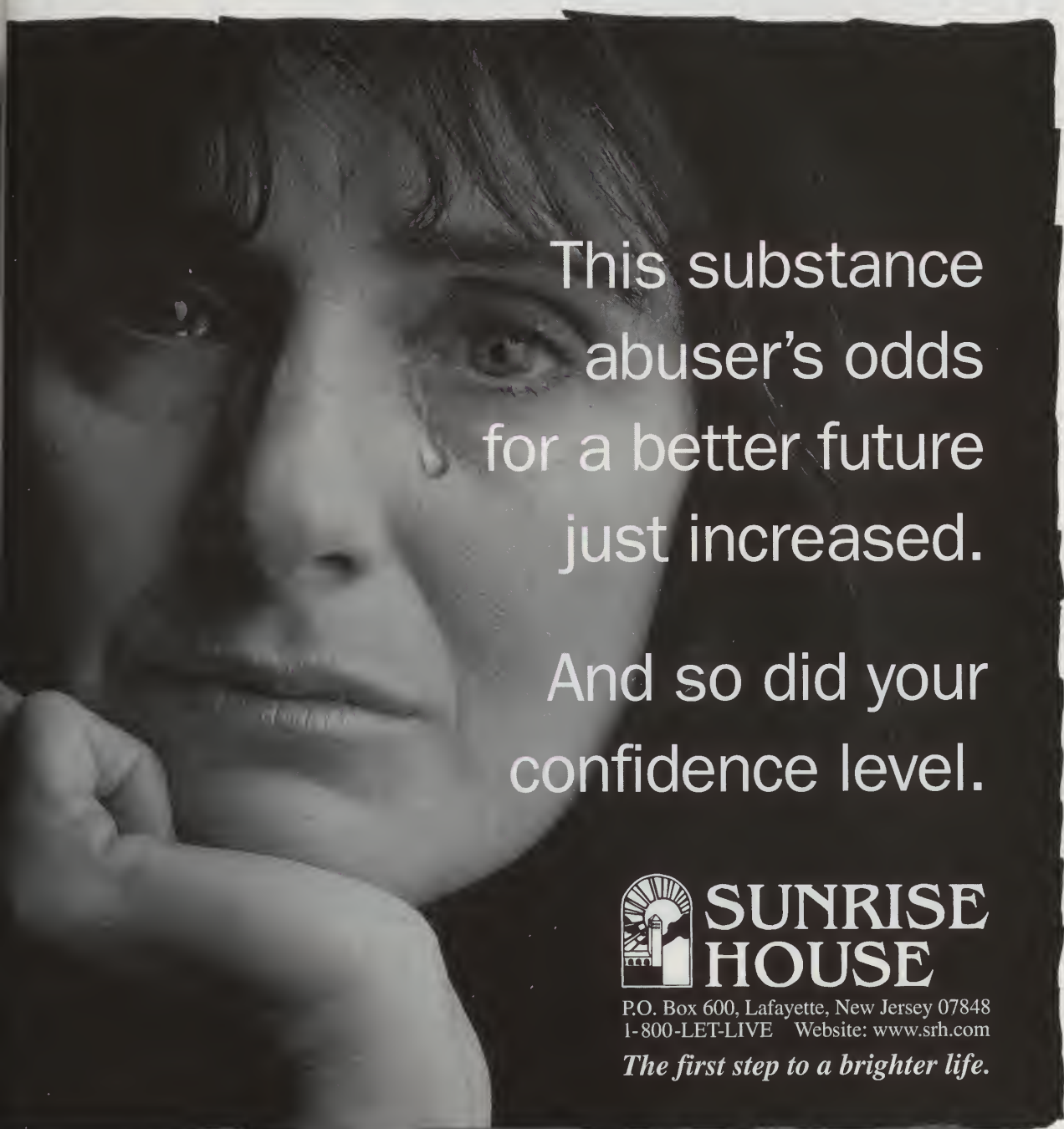
For 14 years, hundreds of tri-state area doctors have trusted us to offer their patients the most effective, caring treatment and a chance for a better life.

Set in the scenic hills of northwest New Jersey, we're a licensed, nonprofit specialty hospital with a nationally known commitment to quality—including Accreditation with Commendation by the JCAHO.

Our comprehensive programs include inpatient and outpatient services, after-care and family support.

And our experienced staff of doctors and specialists works closely with referring physicians to ensure continuity of care at every stage of treatment.

Sunrise House. High-quality, affordable treatment you can trust. For information, call us at 1-800-LET-LIVE or (973)383-6300.



This substance
abuser's odds
for a better future
just increased.

And so did your
confidence level.



**SUNRISE
HOUSE**

P.O. Box 600, Lafayette, New Jersey 07848
1-800-LET-LIVE Website: www.srh.com

The first step to a brighter life.

Sunrise House is a preferred provider of most major insurance companies and HMOs.
We will process insurance benefits verification and precertification.

**Ask the
right questions...**
**Make the
right choices...**

Watch this special
Caucus: New Jersey public television
series and get the information
you need to make informed health care
decisions for you and your family.

caucus
NEW JERSEY
www.caucusnj.org



Hosted by Steve Aducci

Informed Choices has been produced in association
with New Jersey Health Decisions

**NEW JERSEY
HEALTHDECISIONS**
THE CITIZENS' COMMITTEE ON BIOMEDICAL ETHICS

Informed Choices has been made possible by Aetna U.S. Healthcare,
New Jersey Carpenters Funds and Hoffmann-La Roche Inc.



Caucus: New Jersey is a co-production of the Caucus Educational Corporation
Rutgers-Newark, NJN-Public Television and Thirteen/WNET.

Informed Choices

The Best Health Money Can Buy?



Thirteen/WNET
August 29 at 12:30pm
August 30 at 6:00am



NJN - Public Television
August 30 at 10:00am
September 2 at 6:30pm

Is It All In The Genes?



Thirteen/W
September 5 at 12:30pm
September 6 at 6:00am



NJN - Public Television
September 6 at 10:00am
September 9 at 6:30pm

Druker, Rahl & Fein

Business Consultants
Certified Public Accountants

We have your prescription to profitability

We're Druker, Rahl and Fein, the accountants and advisors
to physicians and health care providers.

...Managed Care..Government Regulations
..the industry is changing..quickly.

How will these changes affect your practice?

You have questions and you need answers.

Our medical services experts will assist you
in developing a strategy to
succeed in this dynamic environment.

Leaders in:

Cost Accounting • Strategic Planning • Group Practice Formation • Tax
Managed Care Analysis • Practice Valuations • Practice Management

200 Canal Pointe Boulevard • Princeton, NJ 08540-5998 • 609-243-9700 • FAX 609-243-9799

Contact Robert J. Rahl, CPA

EPILEPSY IN PREGNANCY

WOMEN WITH EPILEPSY HAVE HIGHER COMPLICATION RATES DURING PREGNANCY, LABOR, AND DELIVERY. THESE
INFANTS HAVE HIGHER RATES OF ADVERSE PREGNANCY OUTCOMES, ESPECIALLY CONGENITAL MALFORMATIONS.
CONSIDERATION OF THE SPECIAL TREATMENT OF WOMEN WITH EPILEPSY DURING PREGNANCY IS ESSENTIAL.

B Claudine Sylvester, MD; James L. Breen, MD

Epilepsy affects 0.6 to 1.0 percent of the population. In the United States, there are approximately 2.8 million people with epilepsy; in this group, there are between 680,000 to 1.1 million women of childbearing age with epilepsy.

Although most pregnancies of women with epilepsy (WWE) result in healthy children, data show that WWE do have higher complication rates during pregnancy, labor, and delivery, and their children have higher rates of adverse pregnancy outcomes, especially congenital malformations. Therefore, it is of great importance to understand the epileptic patient and the effect of pregnancy on epilepsy. With a vari-

ety of drugs to treat for the different types of epilepsy, it also is important to understand the adverse effects of these medications (Table).

EFFECTS OF EPILEPSY ON PREGNANCY

It has been suggested that fertility in patients with epilepsy is reduced. WWE seem to have irregular menstrual periods and anovulatory cycles, which may be due to individual seizures causing a transient rise in prolactin levels. Antiepileptic drugs (AEDs) have not been associated with infertility. Studies performed on the pregnancy complications experienced by WWE do not offer conclusive answers as to whether obstetric problems were increased because of epilepsy.

EFFECTS OF PREGNANCY ON EPILEPSY AND SEIZURE FREQUENCY

Many studies performed prior to 1975 show that a significant proportion of WWE experience an increase in seizure frequency during pregnancy. Studies performed from 1982-1991, however, indicate that pregnancy has a limited effect on seizure frequency. In most cases, it is not possible to predict which patients will lose control of seizures, and the occurrence or absence of seizures during previous pregnancies is not a reliable indicator. There is some evidence, however, that patients with frequent seizures, catamenial seizures, or excessive weight gain may be at increased risk for breakthrough seizures.

Numerous physiological changes occur in the body of the pregnant woman, affecting seizure threshold and drug disposition. Increased seizure frequency has been seen most often in the first and third trimesters and in the lactation phase. Estrogen is thought to affect the central nervous system directly by lowering the seizure threshold, whereas progesterone seems to raise it. Estrogen concentrations are proportionally greater than progesterone concentrations in early pregnancy, with the highest ratio found in the first trimester. Psychological factors also may interfere, such as emotional stress, sleep deprivation, and fear of fetal malformation, resulting in noncompliance.

The highest frequency of generalized convulsions seems to occur in the last trimester, while most partial seizures occur during delivery and early puerperium. Remillard found that 83 percent of women with secondary generalized seizures and 67 percent with complex partial seizures had an increase in seizure frequency during pregnancy, whereas only 29 percent of patients with primary generalized seizures experienced an increase. Women who are least likely to have an increase in

seizure frequency are those who have primary generalized epilepsy, have not had tonic-clonic seizures for a year before pregnancy, and have only one type of seizure.

Trauma is the leading nonobstetrical cause of maternal death in WWE, and is an even more common cause of fetal demise. Abruptio placentae is reported after 1 to 5 percent of minor and 20 to 50 percent of major blunt maternal injuries and can contribute to fetal acidosis, hypoxia, and death. Although a grand mal seizure produces strong muscular pressure against the uterus and acute, profound metabolic changes such as lactic acidosis, a healthy fetus is remarkably tolerant to maternal tonic-clonic convulsions. Intrauterine deaths following a seizure have been reported only occasionally. The potential dangers of tonic-clonic seizures to both mother (physical injury, loss of driving privileges, and possibly employment) and fetus (risk of miscarriage and developmental delay) should be reviewed with the patient.

TERATOGENIC EFFECT OF EPILEPSY WITHOUT ANTIEPILEPTIC DRUG USE

Fifteen retrospective studies did not find an increase in the incidence of congenital malformation in epileptic mothers who did not receive anticonvulsant drugs compared with the general population. However, it can be presumed that WWE who are not taking anticonvulsant drugs have much less severe epilepsy than those receiving anticonvulsant drugs, and there remains the possibility that severe epilepsy itself is associated with congenital abnormality.

ANTIEPILEPTIC DRUGS

During the past three decades, there have been many studies that show a definite link between the use of AEDs in WWE and congenital malformations in their children. It is not clear if the complications and congenital malformations are dose related. No study has delineated the relative contribution of medication and of epilepsy, itself, to the increased incidence of congenital abnormalities. While it might seem reasonable to discontinue all AEDs before conception, this course of action is not recommended because one-third of all WWE experience an increased rate of seizures during pregnancy.

In the presence of constant drug dosage, the serum concentration of most AEDs tends to fall as pregnancy advances, and low plasma levels may provoke seizures. Plasma levels

EPILEPSY AFFECTS
0.6 TO 1.0 PERCENT
OF THE GENERAL
POPULATION IN
THE UNITED STATES.

return to the pre-pregnant level within the first month after delivery. A variety of factors can explain the phenomenon of subtherapeutic AED levels during pregnancy, including an increase in protein binding, an increase in hepatic clearance, an increase in the volume of distribution, and a decrease in intestinal absorption.

COMPLICATIONS AS A RESULT OF AEDS USED DURING PREGNANCY

The pregnant woman with epilepsy is likely to become anemic as a result of folic acid deficiency. This is because most anti-convulsant drugs act as antagonists to folic acid. There is a potential risk for vitamin D deficiency for women and their fetuses, who are receiving long-term phenytoin treatment because phenytoin induces the production of enzymes that hydrolyze vitamin D.

AEDs (particularly barbiturates or phenytoin) may depress the vitamin K dependent clotting factors, prothrombin and VII, IX, and X. Coagulation deficiencies leading to massive hemorrhages have occurred in late pregnancy or shortly after birth in the mother and the neonate. These hemorrhages can occur suddenly in unusual intrathoracic or retroperitoneal sites. Post-

THE PREGNANT WOMAN WITH EPILEPSY IS LIKELY TO BECOME ANEMIC DUE TO FOLIC ACID DEFICIENCY.

partum hemorrhage may be the result of uterine hypotonia caused by AEDs. Data on this are controversial; however, the incidence of vaginal bleeding ranges from 5.1 to 31 percent.

CONGENITAL ANOMALIES AS A RESULT OF AEDS USED DURING PREGNANCY

Malformation rates in the general population range from 2 to 3 percent, while malformation rates in

various populations of infants of mothers with epilepsy range from 2.3 to 18.6 percent. These combined estimates yield a risk of malformations in an individual epileptic pregnancy of 4 to 8 percent. There have been numerous studies conducted from 1956 through 1994 that have compared malformation rates in the offspring of mothers with and without epilepsy. It may not be appropriate to combine data from these studies. Some have matched controls, others use population registers, and many have no controls. However, in reviewing these studies a consistent trend is evident. Infants of WVE have roughly two to three times the number of malformations when compared with infants in the general population.

Table. Drugs of choice for epilepsy treatment.

Seizure Category	Drugs of Choice	Alternative Drugs
Primary generalized, tonic-clonic	Valproic Acid Phenobarbital	Carbamazepine Phenytoin Primidone
Primary generalized, absence	Ethosuximide Valproic Acid	Clonazepam
Primary myoclonic	Valproic Acid Clonazepam	Phenytoin Phenobarbital
Partial simple & complex & secondary generalized epilepsy	Carbamazepine Phenytoin	Valproic Acid Phenobarbital Primidone
Mixed forms	Valproic Acid Clonazepam	Carbamazepine Phenytoin Phenobarbital

There are a number of factors that could account for these increased rates of malformations seen in infants of mothers with epilepsy. These factors include maternal seizures during pregnancy, the genetics of maternal epilepsy, falls and injuries secondary to the seizures, lower socioeconomic status, and limited access to prenatal care. However, most studies agree that AEDs are the main cause of the increased malformation rates among infants of mothers with epilepsy.

Mean plasma AED concentrations are higher in mothers with malformed infants than in mothers with healthy children. Infants of mothers on polytherapy have higher malformation rates than those exposed to monotherapy. The risk of fetal abnormality rises from about double the natural risk in women taking two AEDs to nearly four times that risk in those taking four AEDs. It is reasonable to conclude that women who need more AEDs have less controllable epilepsy and, as a result, have an increased risk of congenital anomalies in their offspring. Multiple studies over the last 60 years support the link between WWE on AEDs and congenital anomalies.

The most commonly used AEDs include valproate (Depakene™),

phenobarbital (Luminal™), carbamazepine (Tegretol™), phenytoin (Dilantin™), ethosuximide (Zarontin™), and clonazepam (Klonopin™). No syndromes have been associated with ethosuximide or clonazepam. However, the other four AEDs have well-documented syndromes associated with them.

Antiepileptic drug syndrome, formerly called fetal hydantoin syndrome, includes the anomalies most often seen with valproate, phenobarbital, and phenytoin, such as craniofacial abnormalities (flat nasal bridge, epicanthal folds, broad alveolar ridge), distal digital hypoplasia, nail hypoplasia, microcephaly, and developmental delay. The physical anomalies are obvious at birth and usually are correctable by surgery, whereas the developmental delays appear later.

Other physical anomalies associated with AED use include spina bifida and cleft palate. There is a tenfold increase in the risk of spina bifida with carbamazepine and valproate use. An increased risk also exists for cleft lip and palate with

phenytoin and carbamazepine. There is a 1.8 percent increased incidence of heart defects associated with phenytoin, compared to 0.7 percent in the general population.²¹

NEWER AEDS

The new AEDs being studied are felbamate, gabapentin, lamotrigine, oxcarbazepine, tiagabine, topiramate, and vigabatrin. It is not known whether these new AEDs will affect bone health, fertility, the menstrual cycle, or sexuality. Felbamate, gabapentin, lamotrigine, tiagabine, and vigabatrin do not interfere with hormonal contraception. Whether these new AEDs are good choices for pregnant WWE awaits further experience with the human pregnancy. However, animal reproductive toxicology appears promising. Pregnancy outcomes have been largely favorable, and no consistent pattern of malformation has emerged.

MANAGEMENT OF PREGNANT WOMEN WITH EPILEPSY

WWE of childbearing age need to understand what the risks of pregnancy are to themselves, as well as to their children. If they use AEDs, they need to know the risks associated with their use. Certain steps can be taken before conception to minimize the risk of malformations: switching to single-drug therapy at the lowest effective dose; dispensing multivitamins and folic acid; prescribing vitamin D if the patient is taking phenytoin.



WWE who do not wish to become pregnant must be informed about using oral contraceptives or if they are taking microsomal liver enzyme inducing antiepileptic drugs such as phenytoin, carbamazepine, phenobarbitone, and primidone.

After conception, changing or stopping AEDs in a woman who already is controlled does not reduce the risk of malformations, but does increase the risk of increased seizures. Furthermore, changing or discontinuing antiepileptic medication in a woman who already is pregnant serves little purpose, since most congenital malformations occur within the first six weeks of gestation. Nonetheless, attempts should be made to simplify the therapeutic regimen to monotherapy, and the lowest effective dose of the antiepileptic agent should be given.

At 6 to 10 weeks pregnancy, AED levels (free and total) should be checked. It is better if baseline levels also are ascertained before pregnancy. Between 15 and 18 weeks, the maternal serum α -fetoprotein level should be checked. While this now is routine for all pregnant women, it is more important for WWE because of the increased risk of neural tube defects.

WITH ADEQUATE CARE, WOMEN WITH EPILEPSY CAN BE REASSURED OF GOOD OBSTETRIC AND NEONATAL OUTCOMES.

At 18 to 19 weeks, a detailed ultrasoundogram should be performed, because it then is possible to identify congenital cardiac malformations and neural tube defects (NTDs). If a NTD is suspected, then an amniotic fluid α -fetoprotein level should be obtained. Optimal diagnosis of fetal cardiac anomalies requires the use of color Doppler. Although cleft lip and palate may be detected at this point, they are more likely to be seen at 23 to 25 weeks gestation.

At 34 to 36 weeks, AED levels can be monitored and adjusted accordingly. It also is advisable at this time to prescribe oral phytomenadione (vitamin K_1), 10-20 mg daily. Since many WWE deliver prematurely, it probably is best to begin this therapy by 36 weeks, as it has been shown to prevent neonatal hemorrhage.

PUERPERIUM AND BREAST FEEDING

If an AED dose has been increased during pregnancy, it should be reduced within the first few weeks postpartum.

All AEDs will enter breast milk in low concentrations. However, this is

not a contraindication to breast-feeding unless the drugs concerned are sedatives (phenobarbital, primidone, and benzodiazepines). Phenytoin may cause sedation and the infants who become irritable or listless or feed poorly should be converted to bottle feeding.

CONCLUSION

Statistics are consistent in confirming that, although WWE are at an increased risk for complications and adverse outcomes, over 90 percent of these women have normal healthy children. Thus, only the severely disabled epileptic woman should be discouraged from having children. The patient's neurologist and obstetrician need to work together and establish a plan for treating the patient's epilepsy while she is pregnant. Provided that adequate care is available, the majority of WWE can be reassured of a very good obstetric and neonatal outcomes.

Dr. Sylvester is a second-year resident, Department of Obstetrics and Gynecology, Saint Barnabas Medical Center, Livingston. Dr. Breen is chair, Department of Obstetrics and Gynecology, Saint Barnabas Medical Center.

REFERENCES

1. Avanzini G, et al.: Malformations in offspring in 305 epileptic women: A prospective study. *Acta Neurol Scand* 85:204-207, 1992.
2. Barker LR, Burton JR, Zieve PD (eds): *Principles of Ambulatory*

Medicine. Philadelphia, PA, Williams & Wilkins, 1991.

3. Belai Y, et al.: Outcomes of pregnancy associated with antiepileptic drugs. *Arch Neurol* 51(3):250-253, 1994.

4. Benedetti TJ, Erickson DM, Leavitt M, et al.: Antiepileptics and the development of congenital anomalies. *Neurology* 42(suppl 5):132-140, 1992.

5. Brown KS, et al.: Anticonvulsant teratogenesis: I. A study design for newborn infants. *Teratology* 49:202-207, 1994.

6. Dam M, Gram L (eds): *Comprehensive Epileptology*. New York, NY, Raven Press, 1991.

7. Delgado-Escueta AV, Durner M, Greenberg DA: Is there a genetic relationship between epilepsy and birth defects? *Neurology* 42(suppl 5):63-67, 1992.

8. Delgado-Escueta AV, Janz D: Consensus guidelines: Preconception counseling management and care of the pregnant woman with epilepsy. *Neurology* 42(suppl 5):149-160, 1992.

9. Devinsky O, Yerby MS: Women with epilepsy—reproduction and effects of pregnancy on epilepsy. *Neurologic Clinics* 12(3):479-495, 1994.

10. Erickson DM, et al: Epilepsy in pregnancy: Developmental outcome of offspring at 12 months. *Neurology* 42(suppl 5):141-143, 1992.

11. Friel PN, McCormick K, Yerby MS: Antiepileptic drug dis-

position during pregnancy. *Neurology* 42(suppl 5):12-16, 1992.

12. Gaily E, Granstrom ML: Minor anomalies in children of mothers with epilepsy. *Neurology* 42(suppl 5):128-131, 1992.

13. Grahah JM, Sharony R: Identification of fetal problems associated with anticonvulsant usage and maternal epilepsy. 18(4):933-951, 1991.

14. Hiilesmaa VK: Pregnancy and birth in women with epilepsy. *Neurology* 42(suppl 5):8-11, 1992.

15. Hunt G, Oakeshott P: Carbamazepine and spina bifida. *BMJ* 303(6803):651, 1991.

16. Hunt G, Oakeshott P: Prevention of neural tube defects. *Lancet* 343(8889):123, 1994.

17. Jain S, Maheshwari MC: A prolonged prospective followup study of 306 epileptic patients in New Delhi. *Acta Neurol Scand* 84:471-474, 1991.

18. Kilpatrick CJ, Moulds RFW: Anticonvulsants in pregnancy. *Med J Australia* 154(3):199-202, 1991.

19. Lesser RP, (ed): *The Diagnosis and Management of Seizure Disorders*. New

York, NY, Demos Publications, 1991.

20. Meadow R: Anticonvulsants in pregnancy. *Arch Dis Child* 66(1):62-65, 1991.

21. O'Brien MD, Gilmour-White S: Epilepsy and pregnancy. *BMJ* 307(6902):492-495, 1993.

22. So EL: Update on epilepsy. *Medical Clin NA* 77(1):203-214, 1993.

23. Sowa MV: Use of antiepileptic drugs in pregnancy. *WJ Med* 155(1):64, 1991.

24. Yerby MS: Problems and management of the pregnant woman with epilepsy. *Epilepsia* 3(28):S29, 1987.

25. Yerby MS: Pregnancy, teratogenesis, and epilepsy. *Neurologic Clin* 12(4):749-771, 1994.

26. Tomson I, et al.: A: Epilepsy and pregnancy: A prospective study of seizure control in relation to free and total plasma concentrations of carbamazepine and phenytoin. *Epilepsia* 35:122-30, 1994.

27. Rutherford JM, Rubin PC: Management of epilepsy in pregnancy: Therapeutic aspects. *Br J Hosp Med* 55(10):620-22, 1996.

28. Sawhney, et al.: Pregnancy with epilepsy—a restrospective analysis. *Intern J Gynecol Obst* 54:17-22, 1996.

29. Morrell MJ: The new antiepileptic drugs and women: Efficacy, reproductive health, pregnancy, and fetal outcome. *Epilepsia* 37(S6):S34-44, 1996.

WOMEN WITH EPILEPSY
HAVE HIGHER
COMPLICATION RATES
DURING PREGNANCY,
LABOR, AND DELIVERY.

We know that practicing medicine is your primary concern.

The professionals at Healthcare Management Partners will take away the time-consuming administration and pressures of billing, collections, follow-up, office management, and system maintenance, so you can concentrate on doing what you do best - practicing medicine.

Contact Rosalie Fox or Robert Rahl at 609-734-0443 to find out more.

**Practice Assessments • Billing & Collection •
MIS Systems • Group Practice Formation •
Practice Management • Income Distribution**

**Endorsed Computerized Billing,
Accounts Receivable and
Information Management Company of the
Medical Society of New Jersey**



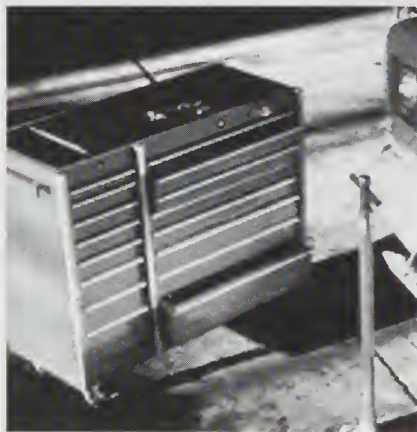
HEALTHCARE MANAGEMENT PARTNERS

PARTNERS IN PROFIT

200 Canal Pointe Boulevard • Princeton, NJ 08540-5998
609-734-0443 • FAX 609-243-9799

A Division of Health Information Consulting Services, Inc.

Only MIIX offers



the Toolkit that fits in your briefcase.

Provided by MIIX Financial Services

The MIIX Toolkit, designed specifically for physicians, explains how you can access:

- Preferred Purchasing Alliance — offering discounts up to 70% on quality medical and office supplies and equipment.
- Equipment Leasing — equipment lease financing and lines of credit at competitive rates.
- Receivables Management — providing collection of medical accounts receivable.

To find out more about this powerful resource,
call MIIX Financial Services at

1-800-227-MIIX.

Endorsed by the

Medical Society of New Jersey

MSNJ

MEDICAL INTER-INSURANCE EXCHANGE



COMPUTERS CONSULTANTS



THE INNOVATIONS OF TODAY ARE THE STANDARDS OF TOMORROW. COMPUTERS ARE BECOMING AUTOMATED CONSULTANTS. SUCH SYSTEMS ENCODE THE KNOWLEDGE OF SPECIALISTS AND MAKE THIS AVAILABLE IN THE FORM OF CONCRETE ADVICE ON TREATMENT. EXPECT COMPUTERS TO TAKE A MORE HANDS-ON ROLE IN PATIENT CARE.

By Eric Lerner

The diagnosis of an abnormality in an electrocardiogram (EKG), the adjustment of a premature infant's respirator, the direction of a cancer patient's therapy are tasks at the core of a physician's skill. Yet in these areas, too, computers are gradually

becoming useful, acting as automated consultants and as the physician's assistant. Such expert systems encode the knowledge of highly experienced specialists and make this knowledge available to a user in the form of concrete advice on treatment. While still confined to a relatively small

number of applications, the usefulness of computers is being proved in careful tests.

Expert systems have proved most helpful in situations where there are many interrelated variables in a treatment program. An example is in the control of mechanical ventilation



for premature infants. The aim of such ventilation, termed intermittent positive pressure ventilation (IPPV), is to maintain the amount of oxygen and carbon dioxide in the blood within an acceptable range, while at the same time gradually minimizing the degree of support and avoiding the complications of ventilation: lung injury and damage to the retina from excessive oxygen.

The problem is complex since there are five independent variables to be adjusted: peak inspiratory pressure, positive and expiratory pressure, time allowed for inspiration, time allowed for expiration, and oxygen concentration in the inspired air. Usually, several variables have to be adjusted at once, especially if one variable is near or at its limit. Yet, given the number of premature infants in an intensive care unit and the number of senior doctors, these decisions often have to be made by relatively inexperienced physicians.

This is a typical situation for an expert system. In the expert system for neonatal intensive care (ESNIC) developed at the St. James University Hospital in Leeds, United Kingdom, rules were developed by two expert pediatricians. First, the levels of carbon dioxide and oxygen were broadly divided into high, low, or normal and for each of the nine possible conditions rules in the form of flow charts were worked out.

When using ESNIC, a physician enters the current ventilation parameters and measurements of blood gases. The program, which keeps a history of the patient's response, suggests an adjustment of the variables. When the system was tested with 63 patients in a neonatal unit with a highly experienced staff, the program was graded by the percentage of times that the attending physician rejected the advice as

inappropriate. In an initial test, the advice was accepted 85 percent of the time, indicating that in most cases the system could be used to help less experienced physicians, although it is far from infallible in its present form.

In ESNIC, an expert system is used as a way of conveying expert knowledge to a broader layer of doctors. However, other systems are intended to help even specialists keep track of complex therapies. In pediatric oncology, therapy involves interlocking protocols in which the timing and dose of various medications are interrelated. Here, an expert system called therapy management in pediatric oncology (THEMPO) proposes a therapy protocol based on patient information entered by the physician. The rules that THEMPO uses to come up with the proposal are based on the experience of several pediatric oncologists and are generally in the form of "if, then" statements: if a given test result is high and this condition exists, try this protocol. The physician can ask the program to give the reasoning used to arrive at a specific suggestion. The physician

AN EXPERT SYSTEM
IS USED TO CONVEY
EXPERT KNOWLEDGE
TO A BROADER LAYER
OF DOCTORS.

either can agree with the suggestion, modify it, or reject it, entering another protocol.

Based on the protocol chosen, the program then calculates doses for the patient.

The physician and nurses can enter all subsequent patient records into the system. THEMPO can automatically detect and alert the physician to test results that appear inconsistent with the diagnosis or between two tests.

At the moment, such a sophisticated expert system remains in the laboratory, as complex issues of how rule-based knowledge easily can be acquired still are to be addressed. Simpler systems that merely aid in the calculation of patient doses already are in clinical use, and more complex systems soon may act as an automatic second opinion for specialists.

One way of easing the difficult process of developing rules for medical expert systems is the use of fuzzy logic, now widespread in other



expert systems applications. Fuzzy logic puts vague but common concepts as "not too high" or "a little less" into mathematical form without forcing physicians or programmers to use hard and fast dividing lines, which often are clumsy or misleading. A fuzzy logic rule ["If test result I drops a good deal, then reduce medication A by a small amount"] is easier to arrive at than an exact one. Fuzzy logic rests on the simple notion that the weight assigned to a particular rule increases the more that a quantity fits into the given fuzzy set. Thus, a person 6 feet tall would be rated as "tall" with a 50 percent weight, but a person 6 feet 6 inches would be "tall" with a 95 percent weight. In this way, vague rules can be given precise mathematical meaning automatically.

The key question for expert systems is whether they actually help

physicians do their job. In some cases, the answer is yes. A recent study looked at one of the most widespread uses of expert system—computer assisted test interpretations (CATI) of EKGs. These expert systems screen millions of EKGs annually for abnormalities. The study had 22 cardiologists analyze 2,000 EKGs either with or without the help of CATI and compared their diagnoses with those of a team of five outstanding EKG experts. When the cardiologist used CATI, there was a substantial improvement in performance—diagnoses the speed of diagnoses increased by nearly 30 percent, agreement with the expert panel rose by 20 percent, and the false positive rate—diagnosing abnormalities that were not there—was cut by more than 50 percent. CATI proved of greatest help when there were a number of abnormalities present in a clear-cut way. In other words, it helped cardiologists avoid overlooking the obvious.

Despite decades of development, medical expert systems remain in their infancy. But the great advances in the capabilities of computers may lead to far more effective systems in the near future.



OF NORTH JERSEY & NEW YORK

is now

ImageFIRST™

MEDICAL WEAR

Lab Coats ■ Dentists Jackets
Patients Gowns ■ Towels ■ Sheets
Pillow Cases ■ And More!

*Changing and improving our
service for you!*

For information call:

1-800-368-3676

MEDICAL BILLING SPECIALISTS

Computerized Electronic Billing Technology.
Eliminate claim processing paperwork.
Let professionals handle your billing headaches.

**LOWEST PRICE
FAST RELIABLE SERVICE GUARANTEED
FOLLOW-UP COLLECTIONS**

**CALL FOR
CONSULTATION**

**MEDICO BILLING INC.
TOLL FREE: 877/901-6475**

FREE TRIAL OFFER AVAILABLE

ANNOUNCING NEW JERSEY'S FIRST

Executive MBA in Health Systems Management

Managing Change in the Business of Health Care

Are you among the growing number of physicians considering an MBA? In today's managed care environment, physicians are being called upon to be smart fiscal managers as well as skilled care providers.

Fairleigh Dickinson University's new 21-month weekend program is designed to build the leadership skills of administrators and physicians in the collaborative management of health care systems. Its weekend format makes it possible for physicians to earn an MBA without interrupting their medical practices. Studies include a two-week summer symposium on international health care issues in England.



*Fairleigh Dickinson
University*

Applications for the Fall 1998 inaugural class are now being accepted. Instruction will take place on FDU's convenient Teaneck-Hackensack Campus. Applicants must have at least seven years of experience.

For a brochure and application packet, contact the
Office of Executive & Special Programs by
Phone: **201/692-7206** or
E-mail: **shurdom@alpha.fdu.edu**

Silberman College of Business Administration

A NEW JERSEY LEADER IN EXECUTIVE MBA PROGRAMS

PUTTING THE PUBLIC BACK IN PUBLIC HEALTH



CHANGES IN FEDERAL WELFARE LEGISLATION AND HEALTH CARE FUNDING HAVE IMPACTED COMMUNITY

PUBLIC HEALTH AND PUBLIC HEALTH SERVICES. LOCAL HEALTH OFFICERS FEEL THE HEALTH OF THEIR

COMMUNITY IS JEOPARDIZED, ESPECIALLY IN AREAS WHERE THE POPULATION IS DISADVANTAGED.

Michael Greenberg, PhD; Dona Schneider, PhD, MPH; Latoya Duncan; Jamie Moskowitz

Welfare in the United States used to mean the federal government gave cash and other forms of aid to support housing, energy, nutrition, and other needs. Health care for the poor was provided through Medicaid. In 1996, the Personal Responsibility and Work Opportunity Reconciliation Act dramatically changed aid to impoverished Americans. The 1996 legislation replaced the Aid for Dependent Children (AFDC) program with block grants to states for temporary assistance for needy people. Eligibility standards for food stamps and supplemental security

income were tightened. Twenty-four months was set as the time limit for receiving benefits without work, and restrictions were placed on life-time benefits.

In 1996, federal health budgets were trimmed, states were given more authority over payments, the Medicare payment system was modified, and the trend toward capitation and other incentive-based payment systems replacing fee-for-service continued.²

In New Jersey, faculty from the Bloustein School of Planning and Policy of Rutgers University and the New Jersey Graduate Program in Public Health discussed the impact of these national changes on public health and reached three tentative conclusions. One was that the national changes in welfare and health care funding would increase morbidity and undermine delivery of public health services. This observation did not seem sufficient to account for changes in local public health programs in the United States, hence, it was necessary to list other actions that undermined public health. State governments, including New Jersey, have been attempting to cut taxes, and state

Table 1. Concerns of New Jersey LHOs.

Changes in welfare and health legislation will lead to the following impacts in my jurisdiction:	Mean ^a	Standard Deviation	Strongly Agree with the Statement (%)
Increase public health problems in the most economically and/or socially stressed areas	2.1	1.0	70
Increase public health problems throughout	2.4	1.1	53
Reduce the number of clinical preventive services	2.8	1.0	46
Reduce maternal and infant health services	2.9	1.1	36
Contribute to increased domestic violence	2.9	0.8	25
Reduce access to family planning services	3.0	0.9	25
Reduce access to emergency care	3.0	1.0	24
Reduce the number of primary care physicians	3.1	1.0	26
Total concern (sum of above 8 scales)	22.2	5.6	NA*

N = 87

^aMean and standard deviation computed from a 5-point Likert scale, where 1 = strongly agree, 3 = neutral, and 5 = strongly disagree.

*Inappropriate calculation.

REDUCTIONS IN PRIMARY
CARE PHYSICIANS,
EMERGENCY CARE, AND
FAMILY PLANNING
SERVICES HEADED THE
LIST OF PROBLEMS.

government's ability to deliver services has been curtailed by these reductions. Local governments are under pressure not to raise property taxes, while at the same time local school budgets are increasing. Hence, we expected local governments to have less public health-related resources. Nongovernmental

organizations (NGOs) often step in when government funding is reduced. However, from anecdotal information, it was hypothesized that NGOs would not be able to aggressively replace government because their resources are in such great demand. Finally, the demographic characteristics of many communities have changed as a result of migration, aging of the population, increasing numbers of single-parent families, and other population shifts. These demographic changes create new public health problems. In other words, the second tentative conclusion was that national changes in welfare provisions and health care payments would be important, but not the only important influence on public health and the delivery of public health services. The third conclusion was that a group of professors were too far removed from the daily activities of public health to know if the first two conclusions are born out by reality. Local health officers (LHOs) were surveyed to compile data on the impacts of federal changes, state and local shifts in policies and resources, and demographic changes. It is imperative to identify LHOs concerns about the impacts of the changes in welfare



provisions and health care funding on their jurisdictions; and to determine correlates of LHOs concerns, such as the extent to which they feel that state and local government support has been reduced and the public health burden on their community has increased during the last five years.

A survey of New Jersey LHOs revealed their concerns about public health in the state. A response rate of 67 percent for the survey was obtained.

LHO CONCERNS

Respondents are clearly concerned that changes in national welfare and health care (Table 1) will lead to increased public health problems throughout their jurisdiction (53 percent), especially in the most disadvantaged areas (70 percent). Forty-six percent believe that clinical preventive services will be reduced and 36 percent note that

maternal and infant health services will suffer. About one-quarter of the respondents were concerned about the reduction of primary care physicians, emergency care, and family planning services, and an increase in domestic violence as a result of the federal legislation. An open-ended invitation to add additional impacts was acted upon by only 14 percent and a few of these noted other issues, including rabies control and environmental protection. To underscore their response, some LHOs wrote their biggest concern and uncertainty was coping with welfare.

Table 2 shows that the most concerned LHOs attributed less ability to improve public health problems during the last five years in their communities to the reduction of state and federal support. LHOs also observed an increasing burden of public health problems in their jurisdictions, and they consider many of the public health problems of their jurisdictions to be more serious than did their less concerned counterparts. The jurisdictions of the most concerned LHOs were dis-

Table 2. Correlates of concern with changes associated with welfare and health care legislation.

High concern is indicated by a low score on the concern scale

Characteristic	Spearman rank Correlation	Average, Most Concerned (n = 35)	Average, Middle Concern (n = 24)	Average, Least Concerned (n = 28)	One-way ANOVA, P-value
Reduction of state support last 5 years	-.356 ^a	2.26 ^c	1.04	1.14	.008
Reduction of federal support last 5 years	-.342 ^a	1.54 ^c	0.25	0.75	.002
Jurisdiction in city 30,000+	.341 ^e	.20 ^c	0.04	0.00	.025
Importance of public health problems in jurisdiction	-.295 ^a	82.2	75.0	75.9	.036
Greater health burden in the community during last 5 years	-.251 ^a	1.29 ^c	0.33	0.50	.011
Less support from local government during last 5 years	-.222 ^b	1.89	1.17	1.14	.159
Per capita income of jurisdiction, \$1,000s	-.198	19.4	20.9	21.8	.352
Less support from local private and public institutions during last 5 years	-.195	1.17	0.50	0.82	.122
Amenability of local public health problems	-.131	70.5	65.3	67.8	.352
Local population less receptive to public health during last 5 years	-.099	1.40	1.13	1.04	.623
Other public health problems require reallocation of resources during last 5 years	-.028	1.34	1.00	1.11	.649

^aCorrelation statistically significant association at $P < .01$.^bCorrelation statistically significant association at $P < .05$.^cMost concerned group is significantly different from other two groups at $P < .05$.^dMost concerned group is significantly different from least concerned group at $P < .05$.^eEta correlation used because dependent variable is two categories.

proportionately central cities of over 30,000 people. All of these associations (5 out of the total of 11) were statistically significant with both tests ($P < .05$).

Amenability to change, reduction of local support, less institutional support, a less cooperative population, and other public health concerns were not statistically significant correlates of impact ($P > .05$). With this caveat noted, the most concerned LHOs were the most likely to think objectives were amenable to intervention, local and institutional support was reduced, the local population was less responsive to local public health programs, and one local public health problem was diverting attention away from another. In addition, the most concerned LHOs tended to come from the least affluent jurisdictions. With regard to the open-ended questions, some respondents wrote in other reasons for diminished capability, but too few and without a consistent pattern to discuss at this point.

DISCUSSION

This initial snapshot of New Jersey LHO perceptions of the



Lucy A. Forgione, president, New Jersey Health Officers Association

impacts of federal welfare and health care legislation produced some expected results. LHOs were most concerned about the impact on areas occupied by disadvantaged people, especially in central cities, and their programs being undermined by the reduction of federal support.

The magnitude of concern and multiple sources of LHO distress were surprising. Sixty percent of the jurisdictions with the lowest per capita income were concerned that the legislation would impact their entire community, not a surprising result. But 45 percent who were responsible for the most affluent places also had the same perception. All eight of the LHOs responsible for central cities felt that public health problems would be exacerbated by the change in federal legislation. But 49 percent of the non-central city LHOs had the same per-

ception. In other words, New Jersey LHOs are telling us that the impacts are more than just a problem for poor and inner-city jurisdictions. This is an extremely important observation because New Jersey has the second highest state per capita income. Some of the LHOs indicating the highest level of concern represent primarily upper middle income and upper income jurisdictions. If community public health is being undermined in New Jersey, we suspect that it must be in greater difficulty in less affluent states.

New Jersey LHOs also noted that this weakened ability to do their job was not solely to be blamed on the federal government. In fact, in New Jersey the strongest correlate of concern is cutback of state support. A recent study by the Tufts Center on Hunger and Poverty observed that New Jersey ranked 43 out of 50 states and the District of Columbia in providing ways of improving the lives of people on welfare.¹⁴ Yet, it is too easy to blame state government. The data and conversations with selected health officers lead to the conclusion that LHOs are responding to cumulative stresses from multiple sources. Federal and state cutbacks head the list, or at least are the most apparent. But, they face local

governments that are concentrating on keeping down local taxes, populations of needy people rapidly increasing in number, and community and philanthropic organizations that are so financially hard-pressed that even these historically reliable sources of aid cannot be counted on for continuing support.

As the only degree-granting graduate program of public health in New Jersey, questionnaire respondents will meet to discuss these issues. Topics will include more discussion on the effects of the welfare and health legislation, working with funding sources, setting priorities, collaborating more effectively with other agencies, and communicating to a public and elected officials who appear not to understand what public health officials do.¹⁵ The purpose of this proposed conference is not to point the finger, albeit blaming is unavoidable. Of greater interest is the opportunity to define more precisely the problems and discuss solutions. Such discussions should help LHOs better cope with a pro-commercial and anti-government environments and

yield information about the effects of health and welfare legislation at the grassroots level.

REFERENCES

1. Wiseman M: Welfare reform in the United States: A background paper. *Housing Policy* 7:595-648, 1996.
2. Rice T: Physician payment policies: Impacts and implications. *Ann Rev Public Health* 18:549-565, 1997.
3. Brown ER: Leadership to meet the challenges to public health. *AJPH* 87:554-557, 1997.
4. Young Q: President's column. *Nation's Health* 28:2, 1998.
5. Medicare: *Nation's Health* 27:1 and 4, 1997.
6. State health report. *Nation's Health* 26:8, 1996.
7. DeParle J: Learning poverty firsthand. *NY Times* April 27; 32-35, 1997.
8. Urban Institute: *Potential Effects of Congressional Welfare Reform Legislation on*

Family Incomes. Washington, DC, Urban Institute, 1996.

9. Hughes MA: Welfare dust bowl. *Washington Post*, September 25, 1996, A23.

10. Medicare: Future unclear as proposals for change emerge. *Nation's Health* 27:1 and 4, 1997.

11. Healthy People 2000: National Health Promotion and Disease Prevention Objectives. Washington, D.C., Dept. of HHS, 1991, PHS 91-50212.

12. Greenberg M, Schneider D, Martell J: Health promotion priorities of economically stressed cities. *J Health Care Poor Underserved* 6:10-22, 1995.

13. Schneider D, Greenberg M, Choi D: Black leaders' perceptions of the year 2000 public health goals for black Americans. *AJPH* 83:1171-1173, 1993.

14. Researchers criticize new welfare policies. *The Times*, February 24, 1998, A9.

15. Widely reported Harris poll says few people understand what "public health" means. *Epidemiol Monitor* 18:4-5, 1997.

DEMOGRAPHICS IN NEW
JERSEY COMMUNITIES
HAVE CHANGED AND
PUBLIC HEALTH NEEDS TO
TRACK THOSE CHANGES.

The authors are members of the Edward J. Bloustein School of Planning and Public Policy. Affiliated with the New Jersey Graduate Program in Public Health, Dr. Greenberg is codirector, Dr. Schneider is a faculty member, and Ms. Duncan and Ms. Moskowitz are research assistants.

1998 Person of the Year

To recognize the top newsmaker
in the state

***New Jersey Medicine* announces competition for the
1998 Person of the Year. This recognition
acknowledges a prominent newsmaker who has
effected change in the health care community
in the Garden State.**

We welcome your nomination.

The Person of the Year will be featured in the cover story of the
December issue of *New Jersey Medicine*.

Please complete the form below and FAX it or mail it
with a 100-word statement explaining why this person
should be selected to:

New Jersey Medicine, Two Princess Road,
Lawrenceville NJ 08648, FAX: 609.896.1368,
e-mail: info@msnj.org

Nominations must be received on or before
October 1, 1998.

hereby nominate the following individual for 1998 Person of the Year:

Name _____
Title/Position _____
Company/Organization _____
Address _____
City _____ State _____ Zip _____
Telephone _____ FAX _____

Nominator's signature _____

Nominator's name (please print) _____

Telephone and FAX _____

New Jersey Medicine Two Princess Road, Lawrenceville NJ 08648
609.896.1766 (FAX) 609.896.1368 e-mail: info@msnj.org

Editorial Guidelines

The principal aim in the preparation of a contribution should be relevance to health care and to the education of health care professionals. The contents of each issue include an important health care development; an indepth interview highlighting a health care newsmaker; an update on a key public health issue; a peer-reviewed clinical report; brief highlights of the latest events and findings in the health care industry; and a monthly forum for readers. Proposals for special submissions will be considered on an individual basis. Letters to the editor are welcome and will be edited and published as space permits. Notices of events, programs, and meetings are encouraged.

Copyright

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or separate statement accompanying material offered to *New Jersey Medicine* must contain the following language, and must be signed by all authors.

"In consideration of *New Jersey Medicine* taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey in the event that such work is published in *New Jersey Medicine*."

Publication Policy


New Jersey Medicine will review original unpublished materials on topics relevant to health care professionals in New Jersey. All submissions are subject to peer review and are edited to conform to the style of *New Jersey Medicine*. Receipt of materials will be acknowledged. Final decision is reserved for the editor. No direct contact between the reviewers and the

authors will be permitted. Upon acceptance, authors will have the opportunity to review edited material. All communications should be sent to *New Jersey Medicine*, Two Princess Road, Lawrenceville NJ 08648.

Specifications

Materials compatible with Microsoft Word 97 for Windows should be submitted on diskette (3 1/2 inch), and should be accompanied by a printed copy of the material, a cover letter identifying the submission, and a copyright form.

The title page should include the full names, degrees, and affiliations of all authors, and the name and address of the author to whom correspondence should be sent.

The author(s) should submit a 50-word abstract to be used at the beginning of the article. References should not exceed 20 citations and should be cited consecutively by superscripted numbers at the end of the sentence. The style of *New Jersey Medicine* is that of *Index Medicus*: I. Goldwyn RM: Subcutaneous mastectomy. *NJ Med* 74:1050-1052, 1977. Tables and graphs should be presented at the end of the article. Illustrations should be of professional quality, black and white glossy prints. The name of the author, figure number, and top of the figure should be clearly marked on the back of each illustration. When photographs of patients are used, the subjects should not be identifiable or publication permission signed by the subject or responsible person must be included. Materials taken from other publications must give credit to the original source. Generic names should be used with proprietary names indicated parenthetically with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol. 

You'll Benefit from this Benefit

MSNJ LEGAL CONSULTANT NETWORK

The New Jersey law firms (*shown in sidebar*) have been carefully previewed and selected as charter members of the Medical Society of New Jersey Legal Consultant Network.

MSNJ members are entitled to register their engagement of any firm in the Network for professional services. MSNJ will monitor the engagement to assure that the MSNJ member, as a client, is satisfied with the services and that the engagement is working for the member's benefit.

To register the engagement, MSNJ members may contact Karen Monsees at MSNJ, 609/896-1766, extension 245.

The Network firms and areas that have been selected are valid for 1998.



**Kern Augustine Conroy
& Schoppmann, PC**
1120 Route 22 East
Bridgewater, NJ 08807
908/704-8585

- All areas of health law and physician representation

Timins, Larsen, Beacham & Hughes
85 Livingston Avenue
Roseland, NJ 07068
201/740-1771

- Employment and commercial law, ethics, health and other insurances, occupational safety and health, probate and real estate

Benesch & Obade, PC
Princeton Pike Corporate Center
993 Lenox Drive, Suite 101
Lawrenceville, NJ 08648
609/844-7590

- All areas of health law pertaining to physicians

Medical Society of New Jersey
MSNJ

A F N D A

EVENT
DATE
LOCATION
S e p t e m b e r

Diagnosis and Management of HIV/AIDS	September 21, 1998	Vineland Developmental Center, AMNJ, 609.275.1911
Oral Cancer Symposium	September 23, 1998	Woodbridge Hilton, AMNJ, 609.275.1911
Domestic Violence Issues	September 23, 1998	Union Hospital, AMNJ, 609.275.1911
Review of New Antibiotics	September 23, 1998	St. Mary's Hospital, Passaic, AMNJ, 609.275.1911
The Future of Medical Rehabilitation	September 25, 1998	Kessler Conference Center, West Orange, AMNJ, 609.275.1911
Emergency Care of Heart Attacks	September 30, 1998	St. Mary's Hospital, Passaic, AMNJ, 609.275.1911
Interhospital Endocrine Rounds	September 30, 1998	University Hospital, Newark, AMNJ, 609.275.1911

O c t o b e r

Treatment of Bulimia Nervosa	October 1, 1998	Carrier Foundation, Belle Mead, AMNJ, 609.275.1911
MRI Symposium	October 6, 1998	Somerset Marriott Hotel, Somerset, AMNJ, 609.275.1911
Sports Medicine '98	October 7, 1998	MSNJ Headquarters, Lawrenceville, 609.896.1766
Blood Glucose Control and Diabetes	October 7, 1998	St. Mary's Hospital, Passaic, AMNJ, 609.275.1911
Interhospital Endocrine Rounds	October 7, 1998	University Hospital, Newark, AMNJ, 609.275.1911
Medical Grand Rounds	October 7, 1998	VA Medical Center, East Orange, AMNJ, 609.275.1911
Cancer Survivorship	October 8, 1998	Caesar's Hotel, Atlantic City, 212.366.6565
Physical Medicine and Rehabilitation Meeting	October 10, 1998	East Brunswick Hilton, East Brunswick, AMNJ, 609.275.1911
Managed Healthcare Forum	October 11, 1998	Washington, DC, 1.800.642.2515
Viral Infections of the Skin	October 13, 1998	Schering Corporation, Kenilworth, AMNJ, 609.275.1911
Care of the Elderly in a Long-Term Setting	October 14, 1998	The Forrestal Center at Princeton, AMNJ, 609.275.1911
Lyme Disease	October 17, 1998	College of Physicians and Surgeons, New York, 212.781.5990
Colitis	October 21, 1998	St. Mary's Hospital, Passaic, AMNJ, 609.275.1911
Interhospital Endocrine Rounds	October 21, 1998	University Hospital, Newark, AMNJ, 609.275.1911
Medical Grand Rounds	October 21, 1998	VA Medical Center, East Orange, AMNJ, 609.275.1911
Endocrinology Lecture	October 21, 1998	VA Medical Center, East Orange, AMNJ, 609.275.1911
Alzheimer's Disease	October 28, 1998	St. Mary's Hospital, Passaic, AMNJ, 609.275.1911
Interhospital Endocrine Rounds	October 28, 1998	University Hospital, Newark, AMNJ, 609.275.1911
Medical Grand Rounds	October 28, 1998	VA Medical Center, East Orange, AMNJ, 609.275.1911
Diagnosis and Management of HIV	October 29, 1998	VA New Jersey Health Care System, Lyons, AMNJ, 609.275.1911



Today, it is not enough to know the latest technology. Reach over the horizon, and grasp the technologies that will change the future...

Emerging Technologies: New Frontiers in Medical Rehabilitation September 25 & 26, 1998

21st Century Medical Rehabilitation
will not just improve function, but will embrace interventions that reverse the impairments that underlie chronic disability.

***Transplantation * Telemedicine *
Sensory Rehabilitation * Robotics *
Voice Activated Computers *
The "Smart House" * Neural Prostheses *
Virtual Reality *
Complementary & Alternative
Therapies * Pharmacological
Approaches to Brain Damage
Recovery * Neural Regeneration *
and evolutionary developments of
today's technologies and therapies...***

***What is the impact on the patient...
what is the impact on society?***



Mark your calendar today for September 25 & 26, 1998 for *Emerging Technologies*, at the Kessler Conference Center, West Orange, New Jersey. CMEs and CEUs will be available. Call KMRREC - Kessler Medical Rehabilitation Research & Education Corporation at 800-332-3221 (ext. 6812) for a brochure and more information or visit us at www.kmrrec.org



You take care of your patients. We'll take care of the health of your practice. Our group of health care accounting specialists provides the medical community with the right type of analysis and counseling to be successful.

Since we're dedicated to increasing your profitability, never simply reporting it, we'll see

to it that your practice stays healthy for many years to come. To experience our unique approach, please call Ira S. Rosenbloom, Managing Director, at 973-882-1100.

PRACTICE GOOD FINANCIAL MEDICINE.



Mintz Rosenfeld & Company LLC

Profitability Consultants • Certified Public Accountants
60 Route 46 East, Fairfield, NJ 07004
Tel: 973-882-1100 Fax: 973-882-1560

OUR FOCUS IS YOUR SUCCESS.



HEALTH LAW PRACTICE

*representing healthcare providers,
including physicians, physician groups, other
clinical professionals, academic medical
centers, multihospital systems, independent
acute care and specialty care hospitals,
ambulatory care centers, and nursing and
assisted living facilities*

For more information or a copy of our
New Jersey Health Law Advisory,
please contact
Alma L. Saravia
51 Haddonfield Road
Cherry Hill, NJ 08002 • (609) 488-7300

DUANE, MORRIS & HECKSCHER LLP
A PENNSYLVANIA LIMITED LIABILITY PARTNERSHIP

Cherry Hill and Newark, New Jersey
with additional offices in
Pennsylvania • New York • Washington, D.C.
Delaware • Florida

In Memoriam

Bastek, James V., MD September 5, 1945–May 22, 1998, UMDNJ (1978), Bergen County, Ophthalmology

Boquist, Walter A., MD May 12, 1912–April 28, 1998, Jefferson Medical School (1938), Warren County, General Surgery

Brown, Jr, Harrison O., MD June 18, 1928–May 29, 1998, University of Virginia School of Medicine (1949), Union County, Internal Medicine

Butenas, Joseph J., MD May 1, 1905–May 27, 1998, Georgetown Medical School (1929), Union County, Trauma and Orthopedic Surgery

Chirovsky, George M., MD February 19, 1952–January 17, 1998, UMDNJ (1978), Morris County, General Surgery

Coughlin, Joseph J., MD July 24, 1906–May 31, 1998, Georgetown Medical School (1936), Bergen County, Surgery

De Sevo, Gerard E., MD October 6, 1911–January 14, 1998, Georgetown University Medical School (1938), Hudson County, Anesthesia

Dorfman, Jacob M., MD September 6, 1910–February 11, 1998, University of Munich, Germany (1937), Middlesex County, Radiology

Faux, Robert G., MD November 5, 1923–January 21, 1998, New York Medical College (1953), Morris County, Obstetrics and Gynecology

Goodman, Harry P., MD March 6, 1919–February 1, 1998, St. Louis University (1944), Atlantic County, Family Practice

Lowenstein, Ernest C., MD February 18, 1909–May 21, 1998, Duesseldorf Medical Academy, Germany (1933), Union County, Family Practice

Mysiewicz, Alphonse T., MD October 30, 1920–January 22, 1998, New York Medical College (1950), Morris County, Orthopedic Surgery

O'Connor, Paul A., MD October 24, 1907–January 2, 1998, Yale University (1935), Essex County, Surgery

Pisciotta, Frank W., MD April 24, 1916–June 6, 1998, Bologna, Italy (1942), Middlesex County, Family Practice

Royal, Andrew B., MD 1911–January 5, 1998, Meharry Medical School (1944), Essex County, General Medicine

Serafini, Louis V., MD January 28, 1915–May 10, 1998, University of Rome (1950), Passaic County, Family Practice

Sobel, I. Jerome, MD July 16, 1899–January 3, 1998, Loyola College of Medicine (1927), Passaic County, Internal Medicine

Zicarelli, Joseph M., MD October 6, 1937–May 15, 1998, New York Medical College (1967), Monmouth County, Obstetrics and Gynecology



ALLEGHENYSM UNIVERSITY HOSPITALS H A H N E M A N N

Grand Rounds and Medical Seminars

September, 1998 through May, 1999

Grand Rounds 8:30 a.m.-9:30 a.m.

Visiting Professorships 8:30 a.m.-12:00 noon

Medical Seminars 8:30 a.m.-3:30 p.m.

Lecture Hall A/B

2nd Floor College Building, Allegheny University Hospitals, Hahnemann

15th & Vine Streets (16th Street Entrance), Philadelphia

For more information, contact the Office of Continuing Medical Education at 215-762-8263.

SEPTEMBER 1998

SEPTEMBER 9th
Perspectives In Iron Overload Disorders

John Gollan, M.D.
Professor of Medicine
Harvard Medical School
Chief of Gastroenterology
Director, Partners Liver Center
Rigmon and Women's Hospital
Boston, MA

SEPTEMBER 18th
**Issues In the Treatment of HIV and
IV Implications**

David Walker, M.D.
Professor of Medicine
Harvard Medical School
Director, Partners AIDS Research Center
Massachusetts General Hospital
Boston, MA

Joseph Pomerantz, M.D.
Professor of Medicine, Biochemistry and
Molecular Pharmacology
Thomas Jefferson School of Medicine
Chief, Division of Infectious Diseases
Director, Center for Human Virology
Thomas Jefferson Medical Center
Philadelphia, PA

SEPTEMBER 23rd
Urethral Tract Infections: A Case Based Approach

Elizabeth Bruyn, M.D.
Professor of Medicine and Public Health
Visiting Chair, Department of Medicine
Allegheny University Hospitals

SEPTEMBER 30th
No Grand Rounds—Yom Kippur

OCTOBER 1998

OCTOBER 7th

Malabsorption

Robert M. Craig, M.D.
Professor of Medicine
Northwestern University School of Medicine
Chief, Division of Gastroenterology
Northwestern Medical Center
Chicago, IL

OCTOBER 14th

Community Acquired Pneumonia:

Update on Diagnosis and Therapy

Michael S. Niederman, M.D.
Professor of Medicine
SUNY, Stony Brook
Chief, Division of Pulmonary and
Critical Care Medicine
Winthrop University Hospital
Mineola, NY

OCTOBER 21st

Interpretation of Randomized Trials and

Their Application in Clinical Practice

Robert L. Frye, M.D.
Professor and Chair
Department of Internal Medicine
Cardiovascular Consultant
The Mayo Clinic
Rochester, MN

OCTOBER 28th

Giant Cell Arteritis

Bruce Hoffman, M.D.
Professor of Medicine
Allegheny University of the Health Sciences
Chief, Division of Rheumatology/Immunology
Allegheny University Hospitals, MCP

NOVEMBER 1998

NOVEMBER 4th

Surviving Heart Failure

William Parmley, M.D.
Professor of Medicine
University of California at San Francisco
Chief, Division of Cardiology
Moffet/Long Hospital
San Francisco, CA

NOVEMBER 11th

Diagnosis and Management of Lung Cancer

Joseph Treat, M.D.
Professor of Medicine
Director, Thoracic Oncology
Allegheny University Hospitals

NOVEMBER 18th

Syndrome X: Ten Years of Experience

Gerald M. Reaven, M.D.
Professor of Medicine
Stanford University School of Medicine
Stanford, CA

NOVEMBER 25th

No Grand Rounds—Thanksgiving Holiday

DECEMBER 1998

DECEMBER 2nd

JNC-VI

Ray W. Gifford, M.D.
Professor of Internal Medicine
Ohio State University College of Medicine
Consultant, Department of Nephrology and
Hypertension
Cleveland Clinic Foundation
Cleveland, OH

Kenneth A. Jamerson, M.D.

Associate Professor of Internal Medicine
Department of Internal Medicine
Division of Hypertension
University of Michigan Medical Center
Ann Arbor, MI

Marvin Moser, M.D.

Clinical Professor of Medicine
Yale University School of Medicine
Senior Medical Consultant
National High Blood Pressure Education
Program
National Heart, Lung and Blood Institute
Bethesda, MD

DECEMBER 9th

Cardiac Auscultation

Bernard L. Segal, M.D.
Professor of Medicine
Allegheny University of the Health Sciences
Philadelphia, PA

DECEMBER 16th

Type II Diabetes Mellitus

Jay Skyler, M.D.
Professor of Medicine
University of Miami School of Medicine
Miami, FL

DECEMBER 23rd

No Grand Rounds—Christmas Holiday

DECEMBER 30th

No Grand Rounds—New Year's Holiday

Wednesday Medical Seminar Series—8:30 a.m. to 3:30 p.m.

SEPTEMBER 16, 1998

Frontiers in the Treatment of HIV

Course Director: Maria J. Gold, M.D.
Seminar Director: Allan B. Schwartz, M.D.

OCTOBER 14, 1998

Diagnosis and Treatment of Pulmonary Infection

Course Director: Edward S. Schulman, M.D.
Seminar Director: Allan B. Schwartz, M.D.

NOVEMBER 11, 1998

Advances in the Management of Lung Cancer

Course Director: Joseph Treat, M.D.
Seminar Director: Allan B. Schwartz, M.D.

DECEMBER 2, 1998

Update on the Management of Hypertension:

JNC-VI

Course Director: Bonita Falkner, M.D.
Seminar Director: Allan B. Schwartz, M.D.

DECEMBER 9, 1998

Cardiac Auscultation for Office Practice

Course Director: Bernard L. Segal, M.D.
Seminar Director: Allan B. Schwartz, M.D.

Seminar Director: Allan B. Schwartz, M.D., Professor of Medicine, Chief of Service, Director of Continuing Medical Education for the Department of Medicine

Disclosure Statement: All faculty participating in continuing medical education programs sponsored by Allegheny University of the Health Sciences are expected to disclose to the audience any real or apparent conflict(s) of interest related to the content of their presentation.

Statement of Accreditation: Allegheny University of the Health Sciences is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education programs for physicians. Allegheny University of the Health Sciences designates 1.0 credit hour of category I of the Physician's Recognition Award of the American Medical Association for each hour of attendance at these continuing medical education activities. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

This program is eligible for 1.0 credit hour for each hour of attendance in category 2A of the American Osteopathic Association.

CLASSIFIED ADS

100 OPENINGS PHYSICIANS (MULTIPLE SPECIALTY)

FAMILY PRACTICE

Excellent opportunity for a physician to join an established Family Practice in Morris Plains, Morris County, New Jersey. Salary commensurate with experience. Will introduce. Terms available. Please fax resume ATTN: FAP (516) 665-0555.

PODELL MEDICAL CENTER

The Podell Medical Center is looking for physicians who are well-trained in conventional and alternative medicine to join our integrative health and medical care center. Please ask for Judy Aiello. Richard N. Podell, MD, MPH, Clinical Professor, Department of Family Medicine, UMDNJ Robert Wood Johnson Medical School. Telephone: 904-464-3800. Fax: 908-464-3078.

110 OPENINGS PHYSICIANS (ALPHABETICAL BY SPECIALTY)

BC/BE ANESTHESIOLOGIST

Pain Management Only—New Jersey (Central/Northern—½ hr. from N.Y.C.). Outstanding private practice opportunity for BC/BE Anesthesiologist. Pain Fellowship is a plus. F/T or P/T. Most established pain group in the state. No night calls or wknds. Avail. 08/01/98. Fax short CV & cover letter to 732-651-0375.

INTERNAL MEDICINE

Internal Medicine. Family Practice. Mercer County/Princeton Area. Seeking BC/BE Internist/Family Practitioner to join busy medical practice in the Mercer County, Princeton Area. Competitive Salary, full Benefits Package. Recent Residency Graduates welcomed. Contact Dr. Joseph De Blasio. 609-586-6006.

RADIOLOGIST

Private imaging center by the Jersey Shore is in need of two Board Certified Radiologists; one Full-time with experience & training in MRI & CT & one Part-time with experience in Mammo, Sonogram & Nuclear Medicine. Send resume to P.O. Box #140, New Jersey MEDICINE, 370 Morris Avenue, Trenton, NJ 08611.

160 PRACTICE TO MERGE

Busy Internist with offices in Maplewood and Warren interested in merging with another internist or group. Would also sublet space to physician, especially if interested in cross coverage—perfect for starting physician or satellite office. Call 973-763-5770 or 908-561-3535.

200 PRACTICE FOR SALE

ENT PRACTICE

Gen ENT practice, solo in own building—established 28 yrs—South Jersey Shore area—15 min to Atl. City, 1 hr to Philadelphia. Enjoy the Shore, fishing, etc. Call 609-823-4273.

300 OFFICE RENTALS AND LEASES

EDISON

Office Space—Edison Medi-Plex Building opposite J.F.K. Hosp. Fully equipped, turn-key. Rent day, full day, night. 732-494-6300.

MILLBURN

Medical Arts Building. Millburn Avenue. Fully equipped, turn key. Rent day, 1/2 day, night. Call 973-376-8670.

MOUNTAIN LAKES PARSIPPANY AREA

Get in on the ground floor! Now leasing office building excellent location on Medical suites from 1000-6000SF. Will suit. 973-316-6900.

310 OFFICES TO SHARE

PRINCETON AND/OR MARGATE

Princeton and/or Margate space to share bright, dynamic rehab. Center. Flexible depending on needs. Call Val 609-581-2400.

420 FINANCIAL SERVICES

ALTERNATIVE FINANCING/MEDIATION

Where do you go when banks say "NO"? Our company has access to an extensive network of Alternative lenders willing to go where traditional banks won't. Business Debts that are overdue can cause real problems. We can help with debt by skillful negotiation. 732-416-0101

500 MEDICAL EQUIPMENT FOR SALE

MOBILE VASCULAR LAB

Life Sciences "modulab" mint condition. Modules: Arterial, Venous PVR, CWD, Doppler, PPG, Phonoangiogram, probes, 5 pairs stereo headphones, remote, foot pedal, screen, Fujitsu color printer, current software archiver, add'l modules available, computerized cart, free company tech training. \$13,500 profitable. 609-384-9000.

EMERGENCY PHYSICIANS

Emergency Physician Associates, a Team Health affiliate, is seeking quality ED physicians for a variety of practice opportunities in NJ, PA, DE, MD, NC and NY.

We offer physicians competitive compensation, flexible schedules, malpractice insurance, a variety of practice settings, and supportive Medical Directors.

Interested candidates may call

1-800-848-EPA-1.



SHORT HILLS

Ideal location for home or office. Gracious 5 bedroom, 3 1/2 bath Colonial in heart of Short Hills. Offered in impeccable condition. Wonderful details including arched doorways, bay windows and hardwood floors. Spacious 5 room attached office with two lavatories zoned for medical professional. Central air throughout. \$695,000. Prudential Brown-Flower Co., REALTORS (908) 766-5666.

John Paul Dizzia, P.C. ATTORNEYS AT LAW

Legal Counseling and Representation to Medical Professionals in administrative, regulatory and disciplinary matters before the State Board of Medical Examiners, the Department of Insurance, the Division of Medical Assistance and Health Services, and in the law relating to professional rights, responsibilities, ethics and practice issues.

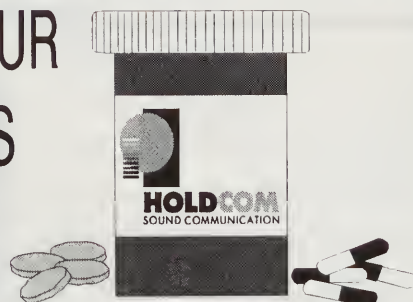
Member:

- National Health Lawyers Association
- Health and Hospital Law Section,
New Jersey Bar Association
- New Jersey Association of
Professional Mediators

North Union Ave.
P.O. Box 886
Ranford, N.J. 07016

Call: (908) 276-6111
FAX: (908) 276-5838
E-Mail: JPDLaw@WORLDNET.ATT.NET

THE RIGHT PRESCRIPTION FOR YOUR CALLERS



Message-On-Hold Systems

Use your telephone music-on-hold feature to:

- Promote Services
- Reassure Callers
- Educate & Inform
- Encourage Referrals

HOLD.COM

Serving the NJ Healthcare Industry Since 1987

Call 1-800-666-6465

<http://www.holdcom.com>

What If There Were a Program to Help Physicians Balance the Demands of Business and Medicine?

There is. *The Institute for Physician Leadership.*

The Institute for Physician Leadership gives physicians an MBA-alternative to learn the leadership skills and management techniques they need to succeed in today's complex healthcare environment.

- Ten 10-hour course modules in monthly sessions that meet Friday afternoons and Saturday mornings in Princeton
- Begins Sept. 11 and runs through July 1999
- Nationally acclaimed faculty tackle issues such as managing change, reengineering and its impact on physicians, opportunities for cost-effective management and new ethical challenges facing physician executives
- Up to 100 continuing medical education credits toward the AMA Physician's Recognition Award

Call 609-275-4149 for a brochure and tuition and registration information. But act soon. Deadline for registration is Aug. 28.

Cosponsored by:

IHRET
HEALTH RESEARCH AND
EDUCATIONAL TRUST OF NEW JERSEY

CBC Center for
Bio-Medical
Communication, Inc.

Medknowledge

THE MEDICAL SOCIETY OF NEW JERSEY CLASSIFIED ADVERTISEMENT INSERTION REQUEST

RATES

(Placement in New Jersey *MEDICINE* OR on WEB Site)

New Jersey *MEDICINE*

<http://www.msnj.org>
WEB Site

Per Month—Non-Members

Minimum 45 words \$ 45.00

plus each word \$ 1.00
over 45 words

Per Month—Members

Minimum 45 words \$ 30.00

plus each word \$ 1.00
over 45 words

Per Month—

Minimum 45 words \$ 45.00

plus each word \$ 1.00
over 45 words

(Placement in New Jersey *MEDICINE* AND on WEB Site)

New Jersey *MEDICINE*

<http://www.msnj.org>
WEB Site

Per Month—Non-Members

Minimum 45 words \$ 45.00 \$ 36.00

plus each word \$ 1.00 \$.80
over 45 words

Per Month—Members

Minimum 45 words \$ 30.00 \$ 36.00

plus each word \$ 1.00 \$.80
over 45 words

PREPARE YOUR COPY ON A SEPARATE PAGE AND ATTACH TO THIS ORDER FORM

INSERTION AUTHORIZATION

Name _____ MSNJ Member? Yes _____ No _____

Company _____ Telephone Number _____

Address _____ Fax Number _____

City _____ State _____ ZIP _____

New Jersey *MEDICINE* Issues _____

Web # of 30 Day Insertions _____

New Jersey *MEDICINE*

Non-Member

Minimum 45 Words \$ 45.00

+ Each Add'l Word @\$1.00 \$

Per Issue \$

X Number of Issues \$

AMOUNT DUE \$

MSNJ WEB SITE

Non-Member or Member

Minimum 45 Words \$ 45.00

+ Each Add'l Word @\$1.00 \$

Per Month \$

X Number of Months \$

AMOUNT DUE \$

New Jersey *MEDICINE*

Member

Minimum 45 Words \$

+ Each Add'l Word @\$1.00 \$

Per Issue \$

X Number of Issues \$

AMOUNT DUE \$

MSNJ WEB SITE WITH

NEW JERSEY *Medicine* Placement

Non-Member or Member

Minimum 45 Words \$

+ Each Add'l Word @\$.80 \$

Per Month \$

X Number of Months \$

AMOUNT DUE \$

TOTAL DUE \$ _____ ALL CLASSIFIED ADS MUST BE PRE-PAID

Please make check payable to "Medical Society of New Jersey"

Mail to: Classified Ad Department

370 Morris Avenue

Trenton, NJ 08611

Tel: 609-393-7196

Fax: 609-393-3759

THE BONES HAVE IT

Osteoporosis is characterized by the loss of bone mass, which leads to reduced strength, poor bone quality, and an increased risk of fractures. Health care costs associated with osteoporosis exceed \$10 billion.

The Osteoporosis Coalition of New Jersey was formed to expand the work of DHSS. The Coalition consists of health professionals, educators, and the general public; its mission is to examine, identify, and make recommendations related to the prevention, identification, and management of osteoporosis. The Coalition has created a publication, *Bare Bone Facts on Osteoporosis*. For this and additional information on osteoporosis, call 609.292.1723.

PERFECT TOGETHER

Commenting that New Jersey and nursing are perfect together, Governor Christie Todd Whitman honored Garden State nurses with the annual Governor's Nursing Merit Award.



recipients

Receiving the award were Jean Marshall, RN; Mary G. Boland, PhD, RN; Mary Barb Haq, PhD, RN; Kyung H. Lee, RN; Lynn R. Tamburrino, RN; Vittoria A. Pointieri-Lewis, RN; Patricia A. Tulli, LPN; and Pamela A. Knight, LPA. The key indicator that people referred to as a measure of quality of their hospital care was their nurse, says a 1997 Nationwide Opinion Focus Group poll conducted by the American Hospital Association.

COMPASSIONATE CARE

Three MSNJ members—Steven Adler, MD, Barry Reiter, MD, and Stephen Schreibman, MD—and Tony Samaha, MD, were honored by Compassionate Care Hospice, in Clifton, with the Physicians Recognition Award.

HAPPY 100TH BIRTHDAY

This year, Greenville Hospital celebrates its 100th anniversary. The Jersey City hospital was founded as German Hospital and Dispensary in 1898, later changing its name in 1912 to Greenville Hospital. "Greenville Hospital has been at the center of the community from the day of its inception," notes Willie Flood, chair of the hospital's Board of Trustees. For additional information on anniversary celebration events or about donating or loaning historical items for the celebration, contact the Office of Administration at 201.547.6106.



Greenville Hospital, c. 1940

VALUABLE VACCINE

In the percentage of the Medicare population that has received pneumococcal polysaccharide vaccine (PPV), New Jersey ranks 39. "We can do better than this," says Ann Hughes, MD, chair of the MSNJ Council on Public Health. "MSNJ encourages physicians to follow the Advisory Committee on Influenza Practices guidelines for PPV." PPV should be given to persons: over the age of 65, with functional and anatomic asplenia, the immunocompromised, chronic cardiovascular disease, chronic pulmonary disease, diabetes mellitus, alcoholism, chronic liver disease, or cerebrospinal leaks. PPV generally is considered safe with mild, local side effects. For more information, contact Lisa Hibbs at 609.896.1766.

Wanted: Top Newsmaker

New Jersey Medicine is accepting nominations for the 1998 Person of the Year award. This award recognizes a prominent newsmaker who has effected change in the health care community in New Jersey. The 1998 Person of the Year will be featured in the cover story of the December issue of *New Jersey Medicine*.

Past recipients include Department of Health and Senior Services Commissioner Len Fishman and UMDNJ past-president Stanley Bergen, Jr, MD. To request a nomination form, call 609.896.1766, extension 259 or e-mail info@msnj.org. Nominations must be received on or before October 1, 1998.



1997 Person of the Year
Dr. Stanley Bergen

PEOPLE IN THE NEWS

The New Jersey Chapter of the American Academy of Pediatrics welcomes its new president, MSNJ member **Michael A. Graff, MD.**



Michael A. Graff, MD

MSNJ member and AMNJ president **Robert R. Rickert, MD,** has been elected chief medical spokesperson for the Eastern Division of the American Cancer Society.

Eduardo Olegario, MD, was named the 1997 Distinguished Physician of the Year by Raritan Bay Medical Center.



Robert R. Rickert, MD

Earl A. Wheaton, MD, received The Valley Hospital Distinguished Physician Service Award.

Irvington General Hospital has appointed **Nancy L. Wollen** as senior vice-president of administration.

The Valley Hospital welcomes **James K. Gerstley, MD,** to its radiation oncology division.



Susan J. Garrubbo

Susan J. Garrubbo, senior vice-president of the Saint Barnabas Health Care System, was honored by the Executive Women of New Jersey.

Director of the Institute for Reproductive Medicine and Science at Saint Barnabas Medical Center, **Paul A. Bergh, MD,** was awarded the Zenith Award by RESOLVE of New Jersey.

PROJECT ORBIS

MSNJ's second vice-president and ophthalmologist **Walter Kahn, MD,** takes medicine around the globe with **PROJECT ORBIS,** an organization that brings skilled doctors to underserved areas to teach native doctors state-of-the-art medical advancements. Kahn, active with the group since 1984, has trained doctors in West Africa, Haiti, the Philippines, India, Latvia, and China. Recently he returned from a three-week visit to Mongolia, teaching native doctors how to perform corrective laser eye surgery. Kahn is affiliated with the Mid-Atlantic Eye Center in Red Bank.



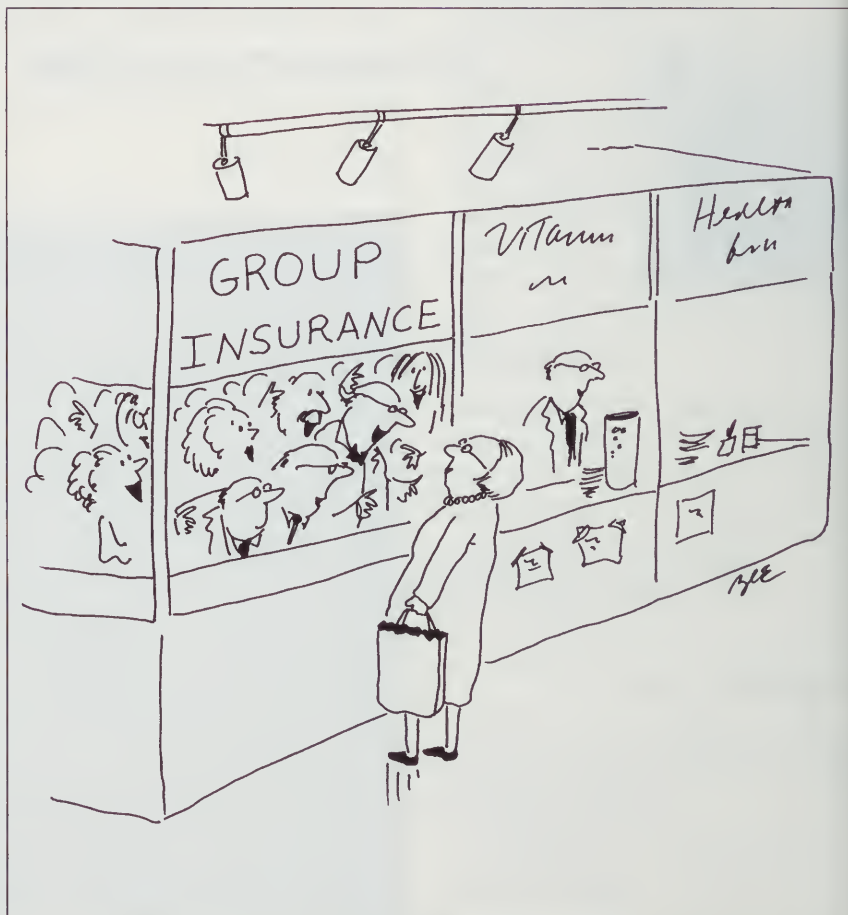
Walter Kahn, MD

NEW JERSEY GOES NATIONAL

At the AMA National Leadership Conference, MSNJ member **Michael S. Goldrich, MD,** presented "The Future of Health Care: The New Face of Medicine in the New Century." Goldrich shared the panel with Jack Lewin, MD, executive vice-president of the California Medical Association; Joseph C. Hutts, CEO of PhyCor; William Porterfield, MD, chair, United Healthcare of Ohio; Daniel Johnson, Jr, MD, AMA immediate past-president; and Robert Waller, MD, of the Mayo Clinic. Goldrich practices in Highland Park, specializing in diseases of the ears, nose, throat, and sinuses.



Michael S. Goldrich, MD



1998 Person of the Year

To recognize the top newsmaker
in the state

***New Jersey Medicine* announces competition for the
1998 Person of the Year. This recognition
acknowledges a prominent newsmaker who has
effected change in the health care community
in the Garden State.**

We welcome your nomination.

The Person of the Year will be featured in the cover story of the
December issue of *New Jersey Medicine*.

Please complete the form below and FAX it or mail it
with a 100-word statement explaining why this person
should be selected to:

New Jersey Medicine, Two Princess Road,
Lawrenceville NJ 08648, FAX: 609.896.1368,
e-mail: info@msnj.org

Nominations must be received on or before
October 1, 1998.

I hereby nominate the following individual for 1998 Person of the Year:

Name _____
Title/Position _____
Company/Organization _____
Address _____
City _____ State _____ Zip _____
Telephone _____ FAX _____
Nominator's signature _____ Nominator's name (please print) _____
Telephone and FAX _____

New Jersey Medicine Two Princess Road, Lawrenceville NJ 08648
609.896.1766 (FAX) 609.896.1368 e-mail: info@msnj.org

Photo Finish

Diane Albala, RN, BSN, offers a helping hand to a recovering patient at The Medical Center at Princeton. As a primary care nurse, Ms. Albala is responsible for coordinating his nursing care.



We welcome contributions to Photo Finish (color or black-and-white). Please include a 50-word description of the photograph. Send to Editor, New Jersey Medicine, Two Princess Road, Lawrenceville NJ 08648. Photographs will be returned.

NEW JERSEY MEDICINE

HEALTH CARE IN THE GARDEN STATE

SEPTEMBER 1998

TEXAS MEDICAL ASSOC. LIBRARY

SEP 16 1998

IN, TEXAS.

Getting the Lead Out



plus
Prison Providers
Health care behind bars

Texas Medical Assoc
Journal Office
401 West 16th St
Austin, TX 78701

Y - O - U - R

PRACTICE

MADE MORE

PERFECT

WITH OVERHEAD EXPENSE INSURANCE FROM BLANKSTEEN

If you get sick, we'd like to help keep your practice well with overhead expense coverage that can reimburse office salaries, rent, insurance premiums, and utilities during an extended disability. Your needs are special, so call and talk with us. The only time to draw a blank in your insurance is when you fill it in with Blanksteen.



The _____ steen Companies

The Blanksteen Companies 253 Washington Street Jersey City, NJ 07302 201-333-4340 1-800-BLANK-AG
The Blanksteen Companies 161 William Street New York, NY 10038 212-732-9435 1-800-BLANK-AG
The MEDICAL SOCIETY OF NEW JERSEY endorsed plans, including Professional Overhead Expense underwritten by National Casualty Company.

SEP 16 1998

AUSTIN, TEXAS

Newswatch

Did we spring ahead or fall behind?

Back-to-school month is a good time to revisit the basics. During the summer, information came to light to shade the basic issues of health plan effects on medical services, improvements in clinical effectiveness, and interactions with government programs and public policy.

In an annual report, Center for Studying Health System Change President Paul B. Ginsburg perceives two overriding developments. First is "the rise of the consumer," whose demand for a choice of health care providers has led to broader provider networks. In Ginsburg's view, the networks now look similar from plan to plan, so that employers find it easier than ever to shift plans without disturbing employees.

In this scenario not only purchasers but also providers can enhance their bargaining power. Mark V. Pauly of the Wharton School told *Perspectives on the Marketplace* that health plans' tout-ing of broad networks "gives providers with enough mass to be

missed more leverage." He also observes the growing power of large plans, however.

The second development is "the re-emergence of public policy," as evidenced by debates over a patient bill of rights. To physician advocates, the two trends are connected. But, the resilience of the connection depends on physicians' willingness to meet rising consumer expectations for information. As corporate medical director Robert Galvin states in *Health Affairs*, "Patients and physicians lack a common knowledge for understanding and discussing health care quality issues." Lee Newcomer, a health plan medical director, follows up by noting that "'mediocre' is the best word" for describing physician and health plan performance under multiple clinical measures.

HEALTH PLAN BEHAVIOR

Which measures are most interesting to consumers in choosing a health plan? Robert J. Blendon and colleagues, also writing in *Health Affairs*, found that "the num-

ber one factor was how well the health plan takes care of members who are sick, followed closely by how much the patients have to pay." The researchers found widespread fear that managed care will compromise quality of care. They did not substantiate Ginsburg and Pauly's impression of the importance of choice of provider.

Are health plans meeting their public responsibilities? Patricia

If physicians want to consolidate to pressure health plans, can they? Federal antitrust enforcement makes consolidation difficult. AMA trustee Donald J. Palmisano, MD, JD, testified before the House Judiciary Committee in favor of legislation to permit physician negotiation. Dr. Palmisano was sufficiently well-received to persuade federal authorities to seek a compromise.

Neuman of the Henry J. Kaiser Family Foundation and colleagues studied Medicare HMOs' promotions. Television advertising images of healthy seniors, lack of wheelchair-accessible seminar sites, and use of small fine print helped convince the researchers that the plans are targeting healthy seniors, not the sick or disabled.

Researchers from Case Western Reserve University learned that plans denied coverage 28 percent of the time for growth hormone therapy for children. According to Beth S. Finkelstein, PhD, and colleagues, the denials came on top of "conservative" referral patterns by primary care physicians and "fairly selective" recommendations by pediatric endocrinologists. The Neuman study was reported in *Health Affairs*, while the Finkelstein study was summarized in the Agency for Health Care Policy and Research's *Research Activities*.

CARING FOR PATIENTS

Research also tends to substantiate a need to improve clinical effectiveness. A study conducted by Paul G. Ramsey, MD, of the University of Washington and colleagues found that primary care physicians often missed important information when interviewing patients. Only one-half of the physicians asked pertinent questions about the patient's complaint or reviewed physical symptoms or the past medical history. The researchers endorse the use of intake questionnaires.

Another study, led by Timothy G. Ferris, MD, MPhil, of Harvard Medical School, noted an increase from 12 to 14 minutes in the average time primary care physicians

spend in the patient encounter, as well as more counseling of young patients. But, the researchers also noted unjustified increases in prescriptions for antibiotics and the stimulant Ritalin®. *Research Activities* summarized the Ramsey and Ferris studies, as well as a study indicating that reliance on evidence-based guidelines for discharging patients with pneumonia could shorten hospital stays. One million people are hospitalized for pneumonia every year at a cost of \$9 billion.

Cost also was on the minds of researchers who explored treatment for depression and determined that health plans could save money by intervening early—medically managing the care—in cases marked by characteristics of high risk of extraordinary use of medical resources. The study was premised on the high consumption of medical resources by depressed patients. Research physician Thomas Croghan and colleagues published their results in *Health Affairs*.

BASICS IN SURVIVAL

Permit a few miscellaneous notes from periodicals referenced above. *Research Activities* includes a piece explaining why black breast cancer patients may experience shorter survival times after diagnosis: missed appointments. We need to

learn how to more effectively overcome cultural barriers to care.

Health Affairs presents a terrific summary of recent events involving change in Britain's National Health Service, written by Rudolf Klein. The piece concludes with a warning that, like their counterparts across the pond, British physicians have been warned "that more rigorous self-regulation was the only alternative to greater managerial control."

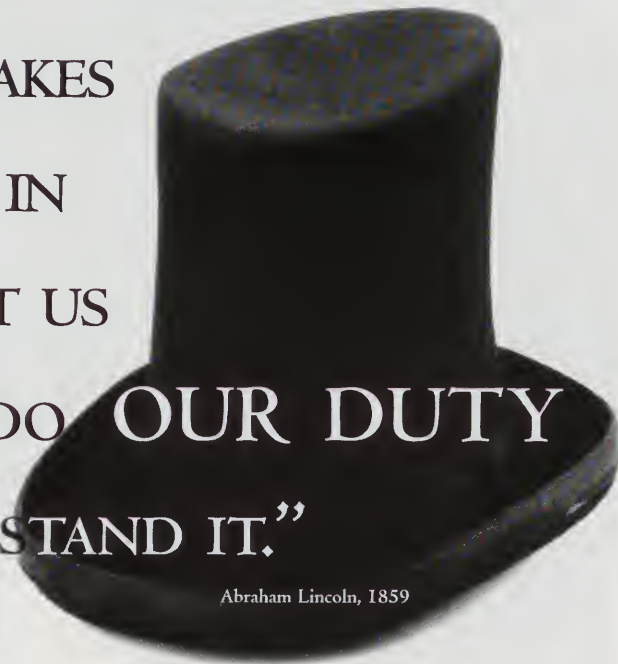
And, in an economic assessment of physician practice management (PPM) firms, James C. Robinson writes in *Health Affairs* that successful firms will be those that balance physician autonomy and income with centralization of information systems and decisions. "It will be important," he declares, "for leading physician systems to establish local brand names and consumer loyalty."

So, now even physicians are becoming identified with corporate "brands." Surely physicians are tired of being told to adapt and to yield to market forces and government. Like patients, clinicians want to play on a field that is not sloped against them. Do we need to go back to school to figure out how, fundamentally, this can be achieved?

Neil E. Weisfeld

“LET US HAVE FAITH
THAT RIGHT MAKES
MIGHT, AND IN
THAT FAITH LET US
DARE TO DO OUR DUTY
AS WE UNDERSTAND IT.”

Abraham Lincoln, 1859



Setting rates is one of the most challenging tasks an insurer faces. At Princeton, we balance doctors' desire for low-cost professional liability insurance protection with the need to bring in sufficient funds to pay claims. Responsible rate setting, including savings for doctors with good claims experience, is in line with our longstanding commitment (one score and counting) to serve policyholders this century and beyond.

For a policy that delivers value in return for your hard-earned premium dollars (and cents), consult one of the independent agents who represent Princeton or call us at **1-800-433-0157**.



Princeton Insurance Company

Professional Liability

Office Package Policy

Workers Compensation

Rated A- (Excellent) by A.M. Best Company 746 Alexander Road • Princeton, New Jersey 08540

FREE POSTER.



Put this full-color poster in your waiting room or other high visibility location. Call for your copy today. And while you're at it, ask about our experience generating outstanding results for companies, organizations and practices as diverse as the Garden State.



THREE BEARS

ADVERTISING • MARKETING COMMUNICATIONS

20 NASSAU STREET, PRINCETON, NJ 08542
609-688-1400

New Jersey Medicine (ISSN-088-5842-X) is published monthly (since 1904) under the direction of the Council on Communications by the Medical Society of New Jersey (MSNJ), Two Princess Road, Lawrenceville, NJ 08648. Printed in Lancaster, PA, by Lancaster Press. Printed in USA. Whole number of issues 1131. Member's subscription (\$10) is included in MSNJ dues. Rates for nonmembers are \$50; outside USA, add \$20. Single copy is \$7.50. Periodicals postage paid at Trenton, NJ, and Lancaster, PA. Copyright 1998 by MSNJ. September 1998. Internet address: <http://www.msnj.org>. E-mail address: info@msnj.org. 609.896.1766. FAX 609.896.1368. Postmaster: Send address changes to *New Jersey Medicine*, Two Princess Road, Lawrenceville, NJ 08648. The appearance of advertising in *New Jersey Medicine* is not a MSNJ guarantee or endorsement of the product or service, by the advertiser. When MSNJ has endorsed a product or program, that will be expressly noted.

NEW JERSEY HEALTH CARE IN THE GARDEN STATE MEDICINE

SEPTEMBER 1998

Editor-in-Chief Howard D. Slobodien, MD
Executive Editor Geraldine R. Hutner, MA
Assistant Editor Nancy M. Propsner, BA
Editorial Assistant Karen Cuozzo, BS
Advertising Cookson Media Services
Ritchie Resource Group
Production Trentypo, Inc.
Graphic Design Three Bears Communication

President and Chair R. Gregory Sachs, MD
President-Elect Irving P. Ratner, MD
First Vice-President Walter J. Kahn, MD
Second Vice-President Angelo S. Agro, MD
Secretary Bessie M. Sullivan, MD
Treasurer Eileen M. Moynihan, MD
Immediate Past-President Carl Restivo, Jr, MD

MEDICAL SOCIETY OF NEW JERSEY BOARD OF TRUSTEES

S. Manzoor Abidi, MD
Stevan Adler, MD
Churchill L. Blakey, MD
Donald J. Cinotti, MD
Rajendra Prasad Gupta, MD
George T. Hare, MD
David A. Ingis, MD
Philip J. Jasper, MD
Elliot M. Kraus, MD
Giovanni Lima, MD
Mark T. Olesnick, MD
Robert S. Rigolosi, MD
Andrew Kunish, MD, *Speaker of the House*
John W. Spurlock, MD, *Vice-Speaker of the House*
Francis J. Lumia, MD, OMSS
Jamsheed K. Najmi, MD, *Medical Specialty Societies*
Sean C. Reinhardt, *Medical Student*
Niranjan V. Rao, MD, *Member-at-Large*
Michael J. Spedick, MD, *Member-at-Large*
Valerie Claps, *MSNJ Alliance*
Carlo Porcaro, MD, *IMG Section*

REVIEW BOARD

Henry Liss, MD, Chair, Paul W. Armstrong, Esq.,
Richard M. Ball, MD, Harry M. Carnes, MD,
Gary S. Carter, Elizabeth G. Christopherson,
Stuart Cook, MD, Ellen M. Cosgrove, MD,
The Honorable Len Fishman, Joseph E. Gonzalez, Jr,
Paul J. Hirsch, MD, Ismail Kazem, MD,
Louis L. Keeler, MD, Carol J. Kientz, RN,
James R. Knickman, PhD, Paul R. Langevin, Jr,
George R. Laufenberg, Martin S. Levine, DO,
Gregg Lubinsky, RPh, Ruth B. Mandel,
Michael R. McGarvey, MD, Julane Miller,
Charles M. Moss, MD, Patricia Murphy, PhD, RN,
Tom O'Neill, Fred M. Palace, MD,
Robert Rickert, MD, Mary Todd, DO,
William H. Tremayne, F. Kevin Tylus,
The Honorable Charlotte Vandervalk,
Joan Verplanck, Paul E. Wallner, DO

Ever wish your broker, your trust officer
and your banker had more in common?



A single vision of your future, for example?

As a physician, you spend a lot of time serving your patients and managing your practice. Where do you find the time to manage the people who manage your financial affairs? At PNC Private Bank, the team of people that manage your financial affairs can be just that: a team. People who work together, with a common goal: to realize your vision of the future. PNC Private Bank brings together under

one roof every service you need, backed by 150 years of professional money management experience and the resources of one of the country's largest financial institutions. No conflicts of interest. No misinterpretations. Just the synergy that can only come when everyone who works with you works with each other as well. Call 1-888-844-1565 to learn more about the difference at PNC Private Bank.

PNC PRIVATE BANKSM

Visit us on the World Wide Web. Our address is <http://www.pncbank.com>

Investments • Trusts • Banking Services

PNC Private Bank is a service mark of PNC Bank Corp. Banking and trust services are provided: by PNC Bank, National Association in Pennsylvania, New Jersey, Kentucky, Ohio and Indiana; by PNC Bank, New England in Massachusetts and Connecticut; by PNC Bank, Delaware in Delaware; and by PNC Bank, FSB in Florida. Members FDIC. Brokerage services are offered through PNC Brokerage Corp, a registered broker-dealer and member SIPC. PNC Brokerage Corp is a subsidiary of PNC Bank, National Association, which is not a broker-dealer.

27

Focus on health care

Health care behind bars

By Suzanne Barlyn

A new managed care system is in place in the New Jersey prison system. Is it working, and at what cost?

31

Special feature

Hunger hides behind many faces

By Sheila Smith Noonan

An eclectic snapshot exists of those in New Jersey who are subsisting on inadequate diets. Are we helping them?

35

Public health advances

Breathing a little easier

By Monroe S. Karetzky, MD

Pulmonary medicine demands practitioners keep current in skill level and training in this rapidly expanding field.

39

Clinical report

Genital prolapse

By David C. Chaikin, MD; Jerry G. Blaivas, MD

Women with genital prolapse exhibit a plethora of lower urinary tract symptoms that need careful evaluation.



Monroe Karetzky, MD,
on pulmonary medicine.



Karen Goldman, PhD,
on the lead law.



Julie Goldman
on hospice care.

Critical Treatment for the Future of Your Practice...



Before It's Too Late

Wilentz, Goldman & Spitzer's Health Care Law Practice Group serves health care professionals regarding: group practice formation and operations; management service organizations (MSOs); physician practice management companies (PPMCs); managed care contracting; physician-hospital organizations (PHOs); independent physician associations (IPAs); restrictive covenants; and regulatory, employment, tax and litigation matters. **Think of us as preventive medicine for your practice.**

For information please call our Health Care Law Practice Group Co-Chairs: Michael F. Schaff at (732) 855-6047 or Francis V. Bonello at (732) 389-5636.

**WILENTZ
GOLDMAN
& SPITZER**
ATTORNEYS AT LAW

**"Helping The Health
Care Professional"**

Woodbridge, NJ
New York, NY
Eatontown, NJ

<http://www.newjerseylaw.com>

45 Current trends

The survival chain: CPR, ASAP

By Robin Rapport

In a medical emergency, every second counts.

And, cardiopulmonary resuscitation is essential to life saving.

49 Health policy

Getting the lead out

By Karen Denard Goldman, PhD; Dana Ostrow; Antonia Ty, MD; George G. Rhoads, MD, MPH

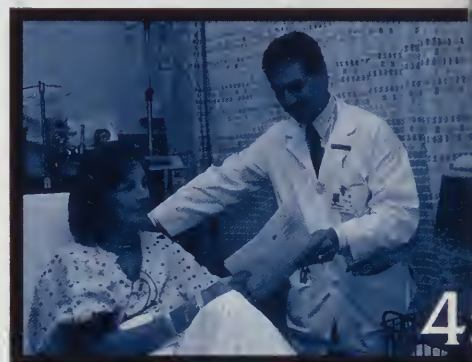
An education initiative reports on the results of physician knowledge and practice about the new lead law in New Jersey.

55 In the spotlight

Interview with Julie Goldman

By Bill Berlin, PhD

She was diagnosed with breast cancer. As a hospice patient, Julie Goldman is teaching physicians about patient care and communication.



Alfred Sacchetti, MD, checks on a patient in the emergency room at Our Lady of Lourdes Medical Center.

DEPARTMENTS

1 Newswatch

The rise of the consumer and the re-emergence of public policy.

12 Mail Stop

An update for physicians concerning Stark II regulations.

15 Editor's Notes

Are HMOs getting a bum rap? It's up to you to decide.

18 F.Y.I.

Breathe better. The gift of life. A new leader for UMDNJ. Sports medicine '98. Lasers lead the way.

21 MSNJ News

An ad hoc committee investigated physician organizing. Read the white paper report.

24 Online @ MSNJ

End-of-life care web sites. Laughter is the best medicine, even on the web. Don't buy, barter.

58 Calendar

Current listing of medical meetings and conferences around the state in the fall and winter.

64 Photo Finish

Fifty years ago, Dr. J. Howard Hornberger asked M to support public health initiatives.



Excel Business Park

501 Prospect Street

Unit 96

Lakewood, NJ 08701

Phone: 732•886•0600

Fax: 732•886•0911

"The overall effect is total customer satisfaction."

- Medical/Dental Cabinetry
- Nurses Stations
- Reception Desks
- Nourishment Centers
- Medical/Dental Procedure Carts
- Computer Desks
- Monitor Cabinets
- Chart Racks
- Corian® Solid Surfacing
Certified Fabricator #C-5112
- Space Planning/Layout

Medi-Bill Associates Offers Advance Funding

Medi-Bill Associates, Inc., a medical billing organization located in New York, offers an innovative Advance Funding program that helps physicians with their billing and cash management needs.

Answering these questions can help you decide if this program is right for you:

Would you like to be paid on Thursday, for assigned patients seen on Monday?

Are complicated billing codes preventing you from maximizing payment on assigned claims?

Are you unable to devote the time necessary to follow-up on submitted claims?

Are your accounts receivable out over 90 days?

If you answered yes to any of the above questions, Call

Medi-Bill Associates, Inc.

The **only** medical billing organization that pays physicians on their assigned claims **within 72 hours!**

Don't Just Bill . . . Medi-Bill!



Medi-Bill Associates, Inc.

Advance Funding/Electronic Billing

Sales: 1-800-546-2414/Operations: 800-386-3771



UNPRECEDENTED ACCOUNTABILITY
CONFLICTING PERFORMANCE CRITERIA
MULTIPLE, FRAGMENTED PROCESSES
TIME-CONSUMING
MORE DOCUMENTATION
LESS PATIENT CARE
HIGH COST
DUPLICATIVE OFFICE-SITE REVIEWS
INCONSISTENT CREDENTIALING
NEVER-ENDING PAPERWORK
ADMINISTRATIVE HASSLES

Our solution has arrived.

One Time

One Source

One Standard



American
Medical
Accreditation
Program

A new American Medical Accreditation Program (AMAP), physicians
make an application **ONE TIME**, have their credentials primary-source
verified **ONE TIME**, and have an on-site office review **ONE TIME**.

AMAP then provides an Accreditation report and certificate to each physician
and sets the AMAP national standard.

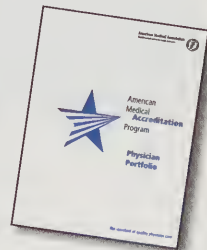
AMAP will provide a complete portfolio of verified credentials, office site
visits, and other frequently requested information to each health plan and
payer that uses AMAP and with whom the physician is affiliated.

American Medical Accreditation Program is a voluntary, comprehensive
accreditation program that measures and evaluates individual physicians
against national standards, criteria and peer performance in five areas:
Medical History, Personal Qualifications, Environment of Care,
Practice Performance, and Patient Care Results.

Meeting and maintaining AMAP's high standard earns a physician AMAP
Accreditation – a new national benchmark of physician quality.

AMAP, your one source for the new national standard of physician quality
information, has arrived.

To learn more about the many benefits
AMAP has to offer *your* organization,
call the AMAP Resource Center at
1-888-881-AMAP (2627) or visit the AMAP
Web site at <http://www.ama-assn.org>.



The standard in quality physician care.

American Medical Association
Physicians dedicated to the health of America



Stark II regulations

On January 9, 1998, HCFA published over 140 pages of proposed new regulations to implement the provisions of the federal Stark II law prohibiting certain physician referrals to health care entities with which the physician or an immediate family member, has a financial relationship, when the referral involves any of the II designated health services covered by Stark II.

Health law commentators have been highly critical of the proposed regulations, which are extremely complex, contra-intuitive, and often unintelligible and internally conflicting. As a result of this resounding criticism, HCFA has advised that it intends to make substantial modifications to the proposed regulations and does not anticipate implementation for at least three years.

Given these facts, it would be an unnecessary and unjustified imposition upon physicians' time, energies, and resources to generally recommend that all physicians attend seminars or seek legal reviews or other action, at this time, to address potential Stark II regulations.

We, though, are making the following recommenda-

tion to physicians: You are at low risk of violating state or federal self-referral and anti-kickback laws and regulations so long as: your income is derived solely from services (as opposed to equipment, supplies, drugs, or supplements) provided by you or full-time employees of your practice; you make no monetary adjustment to compensation, based upon the source of referrals for any of the designated health services within your practice; and you do not offer, or receive, anything of monetary value to or from any person or entity with whom you have a referral relationship or other arrangement that generates business.

If, however, you do not meet the above criteria, and you are participating in any of the II designated health services covered by Stark II, you may be at high risk of illegal activity. In such a case, you should consult with experienced health

care counsel to determine whether remedial action is necessary.

For physicians seeking additional information on the proposed Stark II regulations, we have developed a lengthy internal memorandum providing a detailed analysis of the proposed regulations. It can be found at www.drlaw.com. Physicians in need of legal consultation may call Denise Sanders, Esq, a principal of Kern Augustine Conroy & Schoppmann. Ms. Sanders is the author of this analysis and is a health care regulatory expert who devotes her full professional time to these matters.

Pending further advice from HCFA, we recommend that physicians who meet the above criteria focus their time and resources on assuring that they meet all current billing and coding requirements, including existing E&M record-keeping requirements, that they begin consideration of electronic patient records, which will meet any new E&M requirements, and that they familiarize themselves with the new state regulations on prescribing and dispensing of medications.

Steven Kern, Esq
Kern Augustine Conroy &
Schoppmann
Bridgewater

Requirements for letters

To submit a letter, fax (609.896.1368), e-mail (info@MSNJ.org), or mail your letter to New Jersey Medicine, Two Princess Road, Lawrenceville NJ 08648. Letters should be typed and double-spaced and should be no longer than 400 words with 4 references, if necessary. Include your full name, affiliation, address, and telephone number.

Letters are published at the discretion of the editor-in-chief and are subject to editing and abridgement. Letters may be published on MSNJ's web site, <http://www.msnj.org>. Financial associations or other possible conflicts of interest must be disclosed. Letters represent the opinions of the authors.

*Comprehensive Care
for Your
Financial Health*

M. Sanders & Associates is a full service, all inclusive medical billing, collection and consulting company. We offer professional services to increase our bottom-line profitability by maximizing your reimbursement and improving your productivity.

M. Sanders & Associates has a variety of services available both individually or in combination packages. We can also customize services specifically to meet the needs of your medical practice.

Call Regina Rudd at (609) 661-8011, to arrange for a complimentary consultation and office assessment.

M. SANDERS
ASSOCIATES

Billing, Collection & Consulting Services

A COLLECTIVE WAY TO RESOLUTION

THE RIGHT PRESCRIPTION FOR YOUR CALLERS



Message-On-Hold Systems

Use your telephone music-on-hold feature to:

- ☎ Promote Services
- ☎ Reassure Callers
- ☎ Educate & Inform
- ☎ Encourage Referrals



ORDER ONLINE

PATIENTS ON HOLD LIBRARIES
complete package for Only \$495
go to www.holdcom.com/libraries

HOLD.COM

Serving the NJ Healthcare Industry Since 1987

Call 1-800-666-6465
www.holdcom.com



Druker, Rahl & Fein

Business Consultants
Certified Public Accountants

We have your prescription to profitability

We're Druker, Rahl and Fein, the accountants and advisors to physicians and health care providers.

...Managed Care..Government Regulations

..the industry is changing..quickly.

How will these changes affect your practice?

You have questions and you need answers.

Our medical services experts will assist you in developing a strategy to succeed in this dynamic environment.

Leaders in:

Cost Accounting • Strategic Planning • Group Practice Formation • Tax
Managed Care Analysis • Practice Valuations • Practice Management

200 Canal Pointe Boulevard • Princeton, NJ 08540-5998 • 609-243-9700 • FAX 609-243-9799

Contact Robert J. Rahl, CPA

Our doctors aren't just great. They're the best.



Hudson County's best doctors practice at St. Mary Hospital of Hoboken and St. Francis Hospital of Jersey City. With nearly 600 skilled, caring professionals, our medical staff includes a growing number of leading specialists who are nationally-recognized experts in fields like perinatology, internal medicine and psychiatry.

So when you're looking for a doctor, choose the best.
Call (201) 418-2020.

**ST. FRANCIS
HOSPITAL**
of Jersey City

**ST. MARY
HOSPITAL**
of Hoboken

The best doctors and nurses. Right in your neighborhood.SM

Are HMOs getting a bum rap?

Opinion: Health Care Hysteria, Part II," an op-ed article in *The New York Times* of July 23, 1998, is written by Everett C. Ladd, a professor of political science at the University of Connecticut and president of the Roper Center for Public Opinion Research. Despite the well-publicized efforts of Congress to regulate HMOs in a more patient-friendly way, an effort that has now been politicized almost to extinction, Ladd says the effort is not based on any public ground swell of dissatisfaction; that sentiment is unchanged from 1993-1994, when President Clinton's health care plan was debated and scuttled. (That, of course, was Health Care Hysteria, Part I.)

There has been a continuing barrage of criticism leveled at managed care in the past five years. It has come from physicians, from hospitals, from patients, from legislators, and from the media. It has created unusual bedfellows—patients, physicians, and trial lawyers—working together against the

insurers. The areas of complaint are well documented, iterated, and reiterated. They include:

1. Suppression of types of benefits: those not covered; those denied and subject to appeal; and those truncated for apparent economic reasons, e.g. maternity and mastectomy hospitalizations.

2. Limitation of designated providers: physicians, leading to fractures of long-term relation-

ships; hospitals, removing patients from local neighborhoods; and laboratories, producing delays in reporting and questions about quality.

3. Transfer of money to the companies at the expense of those rendering care. Although the profit of these companies is small by accounting standards, the distributions to shareholders and (especially) to top management is bountiful.

In July, a large local hospital announced the immediate lay-off of 60 workers, with another 60 to follow. It is blamed on reduction of Medicare payments, but the lower and lower fees negotiated with managed care insurers are the root cause of the problem. Twenty nurses are included in the downsizing. When hospital officials were asked why these cuts would not affect patient care, the answer was managed care. Suzanne Gordon, author and public radio health care commentator, relabeled it mismanaged care. She agreed with economists and other observers that shortened stays do not correlate with fewer dollars, that more patients are being readmitted with different diagnoses, and subacute hospital

Howard D. Slobodien, MD



**Until politics are a branch
of science we shall do well
to regard political and social
reforms as experiments
rather than shortcuts
to the millenium.**

J.B.S. Haldane, *Possible Worlds*, 1927.

Editor's Notes

facilities are not monitored or tracked properly. Other hospitals have similar concerns.

New Jersey citizens have been fortunate. The Department of Health and Senior Services promulgated regulations to increase patients' rights, as did the state Legislature. Other states have followed suit. Congress was supposed to create a nationwide level playing field and include those where state law could not. Unfortunately, as noted, that effort is in eclipse.

Professor Ladd's premise seems shaky. But he says figures have changed little from five years ago. He cites polls that give insurance plans a 72 percent "A" or "B" rating. He also mentions a media survey in which "85 percent described themselves as satisfied and 59 percent as very satisfied, compared with only 22 percent as dissatisfied." (Do you feel that either he or we need tutoring in math?) And a dissatisfaction rating of over 20 percent is hardly worth trumpeting.

In the July 27 issue of *Medical Economics*, Michael Pretzer, the Washington editor, also is not sure that Americans "are in a rage over HMOs." He says: "Most Americans, it seems, hold opinions about managed care, and health care in general, that are born of misunderstanding and fear. A majority don't even know whether they are in managed care." The two studies he cites

**The commerce of the
world is conducted by
the strong, and
usually it operates
against the weak.**

**Henry Ward Beecher, *Proverbs*
from *Plymouth Pulpit*, 1887.**

show considerable consumer ignorance about the costs of health care, about the proposed patients' bill of rights, about the numbers of uninsured, and about their own coverage. One poller also feels legislators and other policymakers are influenced wrongly by the public's confusion. However, the president of Matthew Greenwald & Associates, the other polling company, says: "Less than 25 percent of Americans are confident that they will be able to afford health care without suffering financial hardship during the next ten years."

Even more tellingly, Pretzer's pollers report: "Thirty-six percent of Americans think they won't have the freedom to choose their doctor in the future, 22 percent believe they won't be able to get needed treatments, and 25 percent doubt they'll receive quality care. Sixty-one percent believe the ranks of the uninsured will swell during the next ten years. Fifty-six percent fear that Medicare won't be around to see

them through all of their retirement years."

Robert Blendon, professor of health policy and political analysis at Harvard, and similarly qualified associates reported the latest polling data in the July/August *Health Affairs*. The abstract states: "We conclude that the backlash [against managed care] is real and influenced by at least two significant factors: a significant proportion of Americans report problems with managed care plans; and the public perceives threatening and dramatic events in managed care that have been experienced by just a few. In addition, public concern is driven by fear that regardless of how well their plans perform today, care might not be available or paid for when they are very sick."

The Blendon paper had other significant findings: less satisfaction with managed care than with fee-for-service, and that the public probably prefers regulation to report cards and will do so for many years to come.

Congress would do well to revisit the patients' bill of rights. Despite the conclusions of Ladd and Pretzer, John Q. Public is running scared, and his fears cannot be allayed at any lower levels. Meanwhile, the rolls of the uninsured keep climbing. Are we ever going to address this problem? (Sorry to sound like a broken record.)

Wouldn't **you** rather
—
practice medicine
—
than **wrestle**
—
alligators?

Whatever challenges you face
opportunities you contemplate,
right legal counsel can spell
difference between a tangle
complications and a successful
come.

Tamborlane & Printz focuses
des of experience and insight
your needs regarding managed
a contracts, state and federal

We
thought
so.

compliance requirements, and
countless other issues.

Call us and speak with the
attorneys called upon for guidance
by America's most prestigious
medical associations and health law
publications. We'll help you maximize
the rewards and minimize the risks
associated with providing quality
health care.



Tamborlane & Printz, P.C.

Counselors at Law

New Jersey: 908-789-7977 1044 Route 22 West, Mountainside, NJ 07092

Florida: 305-296-2700 1800 Atlantic Boulevard, Suite 208A, Key West, FL 33040

Email: law@tamborlane.com

BREATHE BETTER

Grant-funded New Jersey Breathes (NJB), the anti-tobacco campaign convened by MSNJ, has been awarded a one-year grant extension by The Robert Wood Johnson Foundation, in Princeton. The group was successful in helping to pass the state tobacco tax, which added an additional 40 cents per pack tax to cigarettes. This tax brought the total tax up to 80 cents per pack—one of the highest taxes in the nation. NJB's future, says Larry Downs, NJB project director, may be directed toward indoor air quality with respect to second-hand cigarette smoke.



© Double Exposure

Larry Downs

THE GIFT OF LIFE

Over 58,000 New Jerseyans are waiting to receive transplants. Thanks to the newly established New Jersey Organ and Tissue Donor Registry, becoming an organ or tissue donor just got easier. This statewide database will generate donor awareness, and increase the number of donor organs available for transplant, according to Joseph S. Roth, executive director, New Jersey Organ and Tissue Sharing Network (www.sharenj.org or 1.800.SHARE.NJ).



Joseph S. Roth,
executive director

A WORD FROM DR. SACHS

R. Gregory Sachs, MD, MSNJ president, offered thoughts on the current state of medicine and health care in the Garden State in his inaugural address; the complete address can be found on the MSNJ web site (www.msnj.org); or request a copy, telephone 609.896.1766, ext. 259.

A NEW LEADER

Stuart Cook, MD, a nationally renowned physician, scientist, and leader in academic medicine, has been named acting president of UMDNJ. A nationally recognized researcher of multiple sclerosis and Guillane-Barré syndrome, Cook has built one of the strongest clinical and basic research programs, as chair of the Department of Neurosciences at UMDNJ-New Jersey Medical School. A new member of MSNJ's Review Board, Cook serves as co-chair of UMDNJ's New Jersey Neurologic Institute.



Stuart Cook, MD

LASERS LEAD THE WAY

Cardiovascular disease is the leading cause of death and disability in our country, says the American Heart Association. A new laser procedure, percutaneous transluminal myocardial revascularization (PTMR), says MSNJ member Ronald Rubinstein, MD, chief of interventional cardiology at Jersey Shore Medical Center, may provide a new way of treating cardiovascular disease. The procedure treats patients suffering from angina caused by cardiovascular disease.



(Left) Cardiologist Ronald Rubinstein, MD, and Ed Diamond, technical supervisor of the cardiac catheterization lab at Jersey Shore Medical Center.

KEEP UP TO DATE: THE LATEST IN SPORTS MEDICINE

MSNJ's seminar, Sports Medicine '98, will encompass a wide range of topics, including concussions, spine injury prevention, injuries in the female athlete, and maxillofacial injuries. The seminar will be held on October 7, 1998, at MSNJ, in Lawrenceville. To register, contact Peggy Johnson (609.896.1766).

MSNJ Membership Directory

MSNJ members will be receiving their MSNJ data sheet in the mail in early fall. MSNJ is asking that you review this information, provide any updates or corrections, and return this form to MSNJ offices. This information is included in MSNJ's biennial *Physician Membership Directory* and on the Physician Finder, a section on MSNJ's web site (www.msnj.org). By returning the data sheet, you are assured that the information printed in the *Membership Directory* and on the Physician Finder is accurate. Each member receives a complimentary copy of the *Physician Membership Directory* and a free, level I listing on the Physician Finder. The Physician Finder is a user-friendly resource for the general public and for physicians to quickly locate other New Jersey physicians. Only MSNJ members are listed in the *Physician Membership Directory* and on the Physician Finder. For more information, call 609.896.1766.



Direct AccessSM

for small employers

Visit a specialist
without a referral.

Nationwide access to over 300,000
participating doctors, specialists and hospitals.

Value added discounts for you and your employees from
Sle Vision and CompUSA.

And, announcing a \$25,000 *life insurance program* for small
employer groups that join the MSNJ/BCBSNJ program!

This and more is available when you choose the new
Direct Access health plan from Blue Cross and Blue Shield of
New Jersey—The Medical Society of New Jersey's health
carrier of choice for its members!



BlueCross BlueShield
of New Jersey

Ask us for a free
copy of the SEH
Buyer's Guide.

ISE
INDIVIDUAL &
SMALL EMPLOYER
DIVISION

For more information on Direct Access, and other
health plans for individuals, families
and small employers,
contact the **Medical Society of New Jersey's**
exclusive **BCBSNJ** representative:

Medical Society of New Jersey
MSNJ

Jennifer Altobelli
Sales Representative
973-338-0893

We know that practicing medicine is your primary concern.

The professionals at Healthcare Management Partners will take away the time-consuming administration and pressures of billing, collections, follow-up, office management, and system maintenance, so you can concentrate on doing what you do best - practicing medicine.

Contact Rosalie Fox or Robert Rahl at 609-734-0443 to find out more.

**Practice Assessments • Billing & Collection •
MIS Systems • Group Practice Formation •
Practice Management • Income Distribution**

**Endorsed Computerized Billing,
Accounts Receivable and
Information Management Company of the
Medical Society of New Jersey**



HEALTHCARE MANAGEMENT PARTNERS

PARTNERS IN PROFIT

200 Canal Pointe Boulevard • Princeton, NJ 08540-5998
609-734-0443 • FAX 609-243-9799

A Division of Health Information Consulting Services, Inc.

The MSNJ Committee on Physician Organizing

The following report was presented to the MSNJ Board of Trustees last month. This is the report of the Committee on Physician Organizing. Its members are: Bessie M. Sullivan, MD, chair; Angelo S. Agro, MD; Walter J. Kahn, MD; Irving P. Ratner, MD; R. Gregory Sachs, MD.

On March 15, 1998, the MSNJ Board of Trustees established an ad hoc committee to explore issues related to physician organizing. This report presents the committee's selected findings and recommendations for action.

Medical care in New Jersey is reeling under the juggernaut of so-called "managed care," an engine with many parts, all calibrated to reduce health expenditures to the maximum extent practicable and

permissible. Physicians, in particular, are forced into new and distressing behaviors of justifying their professional decisions, documenting their efforts in excruciating detail, and pleading for payments due them by law and contractual obligations.

In this context many physicians understandably are seeking new organizational opportunities. The valid, necessary goal of physician organization building—within organized medicine and other forums—is the empowerment of the profession of medicine. For physicians are the most highly trained and dedicated of professionals, clearly serving as the pre-eminent practitioners and advocates of high-quality care for all patients, regardless of payment source.

For many years, employed physicians have successfully and legally joined together in unions and similar "collective bargaining" units. But, current federal antitrust laws

and other legal barriers impeded the organizing of freestanding physicians into bargaining units. (Freestanding," in this context, means not directly employed by corporations or other entities.) Antitrust laws do not now function to "level the playing field" or even to assure that the goals are evenly laid out.

RECOMMENDATION

Your committee, therefore, first recommends that the Medical Society of New Jersey, through its own offices and in concert with the American Medical Association, continue to seek antitrust reform and urge all physicians to promote antitrust reform to their U.S. senators and representatives in Congress.

The concentration of wealth and power within the insurance industry, including health maintenance organizations (HMOs), requires physicians to respond in kind. Properly managed single specialty or multispecialty independent practice associations (IPAs), larger

group practices, and other consolidating approaches best equip physicians to obtain sufficient market clout to protect themselves, their professional autonomy, and the needs of their patients.

RECOMMENDATION

Accordingly, your committee recommends that MSNJ advise and support its members to explore ways to legally acquire market share and to promote high-quality care through well-run IPAs and other organizational mechanisms.

The Society should be an "education-al resource and prime mover" in assisting physicians to deal effectively with the business milieu imposed by managed care.

Through hard-won and important legislative and regulatory victories, MSNJ and other health care "provider" and "consumer" groups have sculpted protections that are as imposing and durable as any in the country. To illustrate, those protections include: bans on retaliation against physicians for serving as patient advocates; bans on gag clauses; requirements that HMOs and other carriers have medical

directors accountable to the New Jersey state Board of Medical Examiners; requirements of timely physician access to the physicians who deny approvals for service; requirements that denials conform to written protocols developed with input from practicing New Jersey physicians; interest requirements for HMOs that delay payments on claims; and multiple enforcement mechanisms with stringent penalties.

In many situations, physicians have not yet managed to avail themselves of the opportunities afforded by these protections.

RECOMMENDATION

Your committee recommends that MSNJ encourage its members to use protections contained in the state's HMO regulations, Health Care Quality Act, interest penalty provisions, and related controls on managed care entities.

Although impressive, these protections do not go far enough. Stiffer controls are needed to assure that managed care entities do not trample on the rights of health professionals and patients.

RECOMMENDATION

Your committee recommends that the Board of Trustees instruct its officers to seek protections against one-sided contracts of adhesion in which HMOs unilaterally dictate terms to physicians. New protections against payment delays and absurd documentation demands also must be sought.

In our view, implementation of these recommendations will forge a new spirit of patient care.

A fair and equitable system would gain the confidence of the physician community and our fellow providers, patients, and payers. Even with standing up for our own interest, we should be sensitive to payers' needs for cost controls and appropriate documentation. And no consideration—not our own interest and not the needs of payers—should be allowed to permit any physician to betray the trust of any patient or family.

We thank the Board for permitting us to develop this report for consideration. As adopted, the report should be widely disseminated among New Jersey physicians.

Whether it's an alcohol or drug problem, count on Sunrise House for expert help.

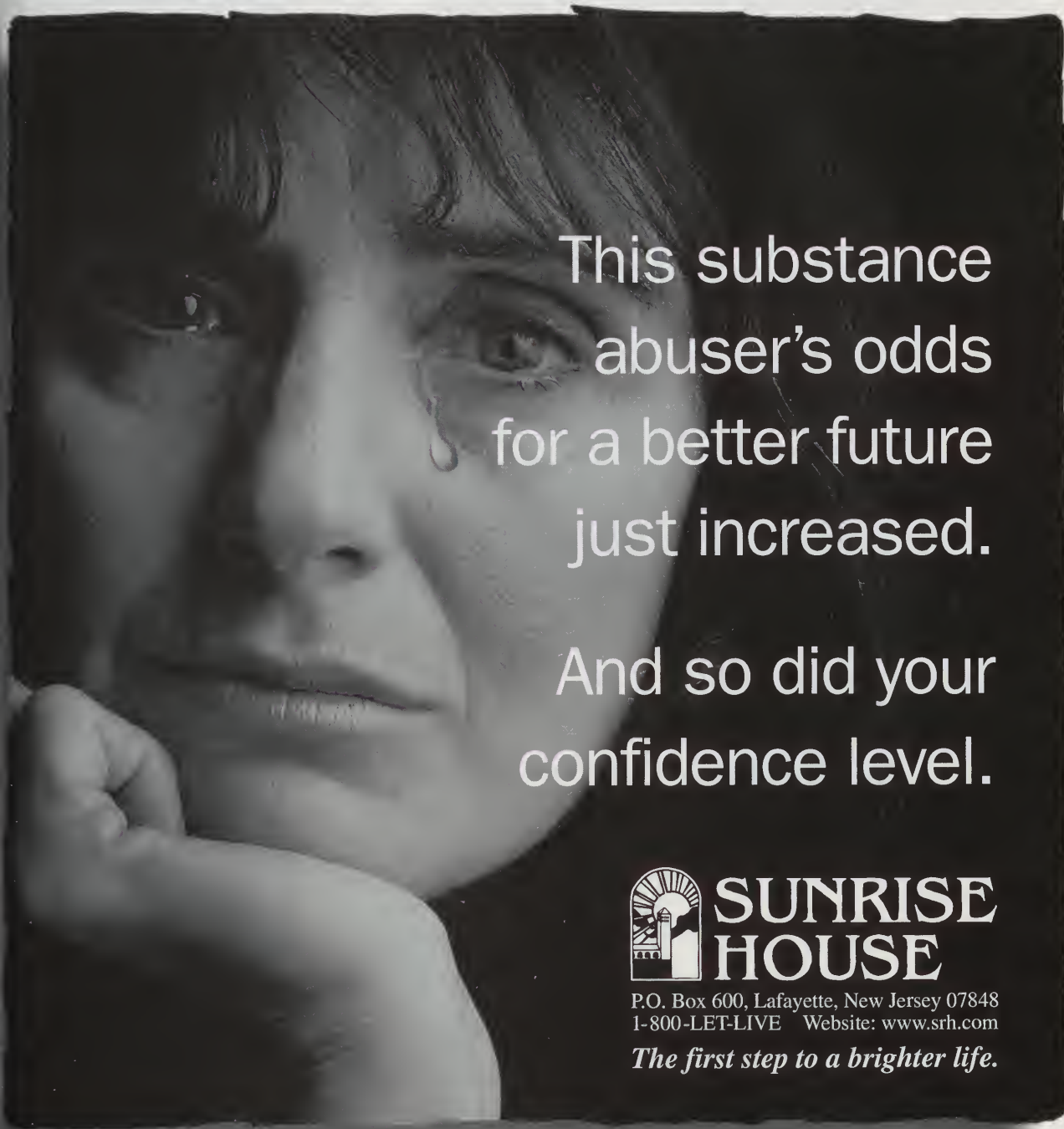
For 14 years, hundreds of tri-state area doctors have trusted us to offer their patients the most effective, caring treatment and a chance for a better life.

Set in the scenic hills of northwest New Jersey, we're a licensed, nonprofit specialty hospital with a nationally known commitment to quality—including Accreditation with Commendation by the JCAHO.

Our comprehensive programs include inpatient and outpatient services, after-care and family support.

And our experienced staff of doctors and specialists works closely with referring physicians to ensure continuity of care at every stage of treatment.

Sunrise House. High-quality, affordable treatment you can trust. For information, call us at 1-800-LET-LIVE or (973)383-6300.



This substance
abuser's odds
for a better future
just increased.

And so did your
confidence level.



**SUNRISE
HOUSE**

P.O. Box 600, Lafayette, New Jersey 07848
1-800-LET-LIVE Website: www.srh.com

The first step to a brighter life.

Sunrise House is a preferred provider of most major insurance companies and HMOs.
We will process insurance benefits verification and precertification.

END OF LIFE

Turn to the web site, Last Acts (www.lastacts.org), for end-of-life resources. The site, funded by The Robert Wood Johnson Foundation, in Princeton, is a call-to-action campaign that serves as a database of information, aids in problem solving, and advocates for better end-of-life care. The goal is to bring end-of-life issues to the forefront and help individuals, families, and organizations find innovative ways to care for the dying.



Susan Bauman, MD, chair of the MSNJ Committee on Biomedical Ethics

MSNJ's web site (www.msnj.org) also provides end-of-life materials. You can access advance directives and policy for physicians and EMS personnel concerning DNR orders for patients located outside of a hospital or long-term care nursing

facility. Go to the "Membership Matters" section, then to "Publications."

THE LAST LAUGH

If laughter is the best medicine, get your daily dose online. There's a growing number of sites dedicated to medical and health care humor. You'll find jokes, anecdotes, and witty words. Check out Medical Bloopers (www.ep-publishing.com/bloopers.html); Humor Matters (www.humormatters.com); Jest for the Health of It (jesthealth.com); and Journal of Nursing Jocularity (www.jocularity.com/).

DON'T BUY, BARTER

Do you have a basement of stuff you don't want? A closet full of clothes you don't wear anymore? Use the barter system to get items you really want. You also can barter services. At Ubarter (www.ubarter.com), consumers can trade items they don't want for items more appealing to them. Post an item and list what you would like to get in return or scan item lists and see if anything appeals to you. When a barter is completed, Ubarter charges both parties a small transaction fee.

BOOKMARKS

hippo.findlaw.com

This site keeps you on top of the rapidly changing health care laws policy, and regulations.

www.kessler-rehab.com

Designed for patients with disabilities and health care professionals; find out what's going on at Kessler facilities.

weber.u.washington.edu/~ekay

Get practical information on undersea medicine and diving safe at Doc's Diving Medicine Home Page developed by Edmond Kay, MD, diving physician for the University of Washington Diving Safety Program.

www.humed.com

Claiming to be "the first university hospital on the net," refer to Hackensack University Medical Center's web site for an overview of the medical center and "Health Topics."

www.caucusnj.org

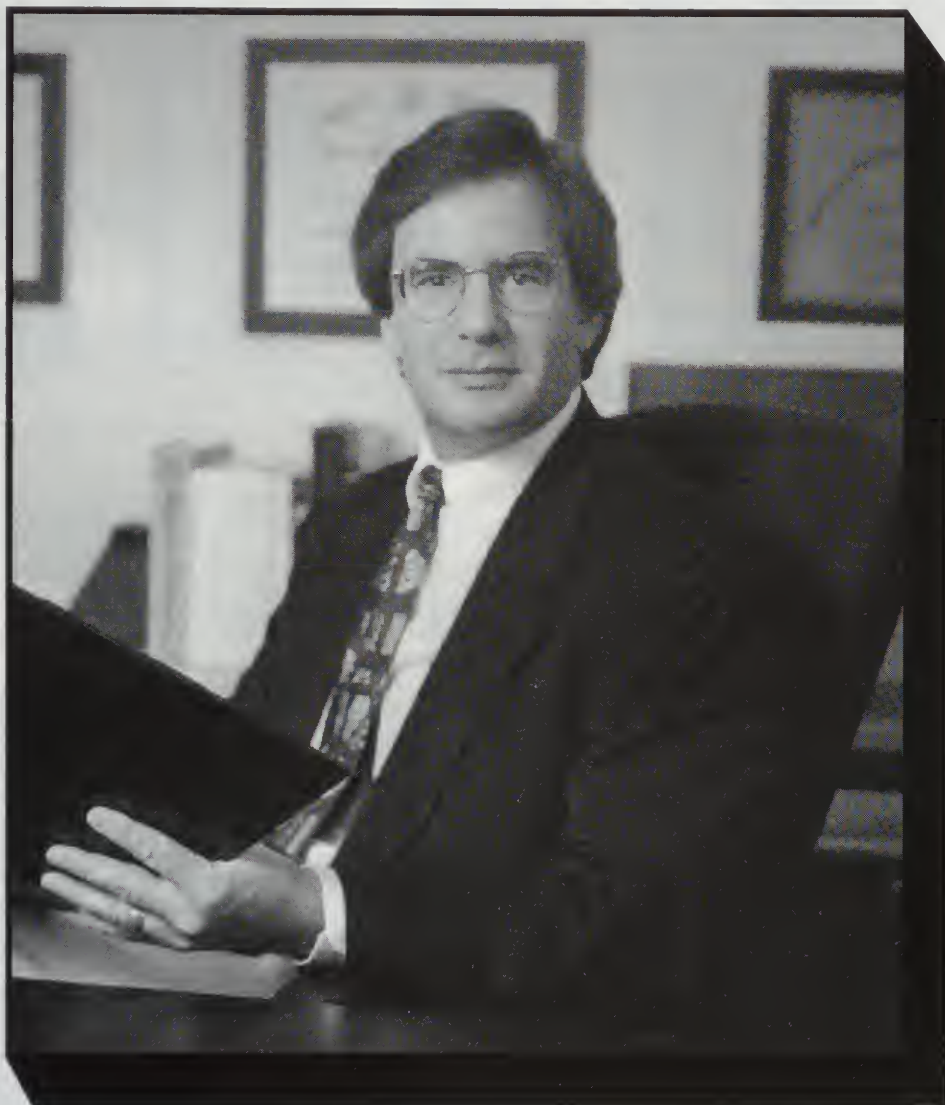
Find out what's going on in the Garden State with the television show *Caucus: New Jersey*, hosted by Steve Aduato.

www.aafp.org

Patient information that can be used to initiate physician-patient conversation.



Steve Aduato



Stuart M. Hochron, M.D., Esq.

Physician Legal Representation

- Group Practice Formation
- Physician Litigation
- Federal Regulation
- Board of Medical Examiners

Practicing Physician, Twenty Years
Clinical Professor, UMDNJ-RWJMS
Research as Highlighted on CNN
AMA Physician Referral Service
Partner, Richmond, Hochron & Burns



phone: (732) 821-0200 fax: (732) 422-9444 e-mail: MDLAWSMH@aol.com

209 North Center Drive North Brunswick, New Jersey 08902

The Medical Manager[®]

Practice Management Software

A fully integrated practice management solution

Over 16 years' experience in providing healthcare automation solutions

Provides an open system architecture and flexibility for specialized needs

Designed for small group practices to large Integrated Delivery Systems

Overwhelming national presence

Learn more about how Medical Manager Corporation and The Medical Manager system can meet your needs. Contact us at 800.677.7784, 201.808.0088, or www.medicalmanager.com.

Medical Manager

Corporation
RTI, Inc. and Medix

Empowering the Industry Through Partnership

John Paul Dizzia, P.C.

ATTORNEYS AT LAW

Legal Counseling and Representation to Medical Professionals in administrative, regulatory and disciplinary matters before the State Board of Medical Examiners, the Department of Insurance, the Division of Medical Assistance and Health Services, and in the law relating to professional rights, responsibilities, ethics and practice issues.

Member:

- National Health Lawyers Association
- Health and Hospital Law Section, New Jersey Bar Association
- New Jersey Association of Professional Mediators

108 North Union Ave.
P.O. Box 886
Cranford, N.J. 07016

Call: (908) 276-61
FAX: (908) 276-58
E-mail: JPDLEGAL@AOL.CO

Lowest Premiums for Quality Malpractice Insurance

The Joseph A. Britton Agency can help make it happen. If you are a preferred risk¹, you can qualify for preferred rates². Compare these annual premiums at occurrence limits of \$1,000,000/\$3,000,000:

• Anesthesiologists	\$ 8,572
• General Surgeons	\$18,453
• Internists	\$ 5,331
• Ob-Gyns	\$39,000
• Radiologists	\$ 5,331
• Plastic Surgeons	\$23,350
• Psychiatrists w/ect	\$ 2,937
• Urologists	\$11,993

With more than 25 years of experience, the Britton Agency has proven exceptional in packaging malpractice insurance. Our professional staff and size assure you the benefits of specialized, personal service while offering you insurance at the lowest cost.

Call for a free consultation. Start saving tomorrow.



Joseph A. Britton Agency, Inc.

Healthcare & Professional Liability Insurance
855 Mountain Avenue, Mountainside, NJ 07092
(908)654-6464 • Fax: (908)654-1422 • 1(800)462-3401

¹Underwriting approval required.

²May need groups of 3 or more depending on speciality.

You take care of your patients. We'll take care of the health of your practice. Our group of health care accounting specialists provides the medical community with the right type of analysis and counseling to be successful.

Since we're dedicated to increasing your profitability, never simply reporting it, we'll see

PRACTICE GOOD FINANCIAL MEDICINE.

to it that your practice stays healthy for many years to come. To experience our unique approach, please call Ira S. Rosenbloom, Managing Director, at 973-882-1100.



Mintz Rosenfeld & Company LLC

Profitability Consultants • Certified Public Accountants
60 Route 46 East, Fairfield, NJ 07004
Tel: 973-882-1100 Fax: 973-882-1560

OUR FOCUS IS YOUR SUCCESS.

HEALTH CARE BEHIND BARS

PROVIDING HEALTH CARE TO NEW JERSEY INMATES HAS BEEN MANDATORY SINCE 1976. WITH RISING COSTS,

THE STATE TURNED TO PRIVATIZATION. A NEW MANAGED CARE SYSTEM NOW IS IN PLACE, BUT IS IT WORKING?

INMATES NEED A VARIETY OF HEALTH CARE SERVICES, BUT AT WHAT COST?

Suzanne Barlyn

Inmates share little in common with New Jersey's law-abiding citizens except, perhaps, a health care system besieged by astronomical costs. As the expensive reality of correctional medicine continues to permeate the walls of New Jersey's state prison system, privatization offers a money-saving solution. In 1996, New Jersey joined a growing number of states that delegated the responsibility of inmate health care to outside contractors.

Providing appropriate health care to inmates became mandatory in 1976 when the United States Supreme Court decided *Estelle v. Gamble*. The benchmark case held that deliberate indifference to prisoners' serious medical needs violates the Eighth Amendment's ban on cruel and unusual punishment. Today, many prison administrators have adopted extensive community standards developed by the Chicago-based National Commission on Correctional Health Care (NCCHC), in their efforts to meet con-



Drawing blood from a New Jersey inmate as a precaution.

stitutional requirements. Privatization alleviates the financial burden of following the law.

While providing medical care under any circumstance is expensive, correctional medical costs are staggering. In the decade preceding privatization, medical costs for New Jersey's state inmates increased 500 percent, according to Correctional Medical Services (CMS), a St. Louis-based company that serves more than 188,000 inmates in 27 states, including New Jersey's 27,500 prisoners at 14 state correctional facilities. Nationally, the tab is \$3.6 billion.

Prisons are prey to the same crisis that is driving an 8 percent annual increase for the nation's medical care. A growing inmate population and costly illnesses present additional challenges. AIDS treatment alone strains the New Jersey Department of Corrections' (NJDOC) health care budget. The cost of protease inhibitors presently runs between \$9,000 and \$14,000 per inmate, according to Mary Ellen Bolton, chief of staff.

But taxpayers can take solace in New Jersey's three-year contract

with CMS. In 1995, NJDOC spent \$77.4 million to fund its own fee-for-service system for state inmates. When CMS' contract became effective in April 1996, establishing a new managed care system, the state's bill decreased to \$64.7 million. The NJDOC reported a \$17 million annual savings during CMS' first two years. And since CMS assumes the risk of care, privatization may also minimize state liability in malpractice suits.

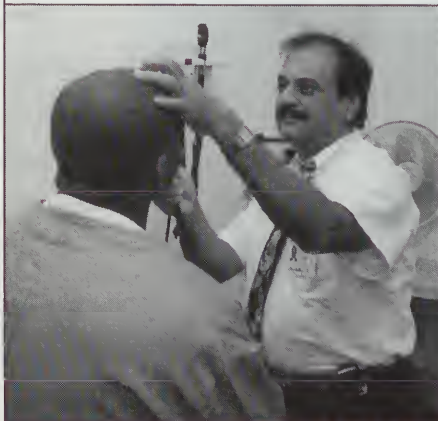
Both CMS and NJDOC also credit privatization with the consistent application of NCCHC community standards. "The care that inmates receive in the north is the same that if [NJDOC] moves them abruptly to the south," says Dr. James Neal, New Jersey statewide medical director for CMS. The contractor has established chronic care clinics at all major facilities to address conditions specific to prison demographics such as infectious dis-

eases, hypertension, cardiovascular disease, and ailments affecting aging inmates, such as arthritis.

State inmates now are subject to the same cost-saving principles that are routine elsewhere, such as shortened hospital stays. Two new "step-down" facilities at Newark's Northern State Prison and Trenton's New Jersey State Prison offer enhanced medical care and permit accelerated release from the state's secure ward at St. Francis Medical Center in Trenton, according to Neal. CMS and NJDOC also are considering plans for a hospice program, according to Chief Bolton.

The measures are crucial, especially in view of ongoing threats to inmate health. "The vast majority of inmates . . . are afflicted with addictive disorders," says Chief Bolton, who also is a registered nurse. "Not only do we have a need to address the addictive disorder, but there are significant complications related to addiction." About 80 percent of state inmates have substance abuse problems while 40 percent are chronic drug users, according to NJDOC. Addictions spawn related health conditions such as HIV, AIDS, renal failure, liver damage, mental health disorders, and violence, says Chief Bolton.

A New Jersey inmate receives preventive health care.



To combat the problem, CMS and NJDOC expanded an existing therapeutic community treatment program. The well-established approach to drug rehabilitation attempts to modify behavior and help inmates examine the root of their addiction, according to Susan Adams, director of communications for CMS. Treatment involves isolating drug-dependent inmates and rewarding them with privileges as they progress, such as increased job responsibilities and television time. Successful participants may continue therapy during work-release and parole.

Despite the advances, some inmates are adjusting to a managed care with the same frustrations that affect millions of Americans outside. A copayment policy, enacted by the state Legislature in 1995, requires inmates to pay \$5 for doctor visits and \$1 for prescriptions. A primary care physician screens inmates prior to approval for specialized care. The change in service providers also has required establishing relationships with a new medical staff.

PRISONS ARE PREY TO THE SAME CRISIS DRIVING AN INCREASE IN THE COST OF THE NATION'S MEDICAL CARE.

"There was a whole new cast of doctors and nurses and an abrupt disconnection in the medical staff who had long been familiar with the medical ailments of the population," says Dharuba Kalahari, a former inmate who was released in 1997 after serving an 18-year bank robbery sentence at New Jersey State Prison.

Inmate advocates agree. Susan Silver, director of Inmate Advocacy of the New Jersey Office of the Public Defender, says she is fielding more health-related complaints since privatization. "The most common complaints I am receiving involve delays in surgeries, specialty care, referrals, and receiving medications."

AIDS- and HIV-afflicted inmates also are concerned about NJDOC's recent efforts to terminate a consent decree established in a 1988 class action suit, *Roe v. Fauver*, according to Laura Abel, an attorney with Gibbons, Del Deo, Dolan,

Griffinger & Vecchione in Newark, who represents the plaintiffs. The decree requires NJDOC to follow meticulous standards of care for treating prisoners with AIDS and HIV. However, NJDOC is now challenging the provisions under the Prison Litigation Reform Act, a 1996 federal law designed to reduce inmate litigation. The state contends the decree requires micro-management of the prison health care system and interferes with its ability to provide effective treatment.

Despite the legal debates, CMS estimates that inmate medical-related lawsuits have declined by 39 percent during the first two years of its contract. NJDOC also maintains that complaints regarding medical treatment were higher, prior to the CMS contract term.

Although taxpayers may bristle at a guaranteed right to inmate medical care, the implications may affect the state's overall physical and financial health. Approximately 95 percent of prisoners eventually return to their respective communities, according to Chief Bolton. "It's appropriate to provide inmates with health care service that will protect the state, not only from communicable diseases and other ill health, but also . . . from . . . claims of professional malpractice," she says.

Only MIIX offers



the Toolkit that fits in your briefcase.

Provided by MIIX Financial Services

The MIIX Toolkit, designed specifically for physicians, explains how you can access:

- Preferred Purchasing Alliance — offering discounts up to 70% on quality medical and office supplies and equipment.
- Equipment Leasing — equipment lease financing and lines of credit at competitive rates.
- Receivables Management — providing collection of medical accounts receivable.

To find out more about this powerful resource,
call MIIX Financial Services at

1-800-227-MIIX.

Endorsed by the

Medical Society of New Jersey
MSNJ

MEDICAL INTER-INSURANCE EXCHANGE



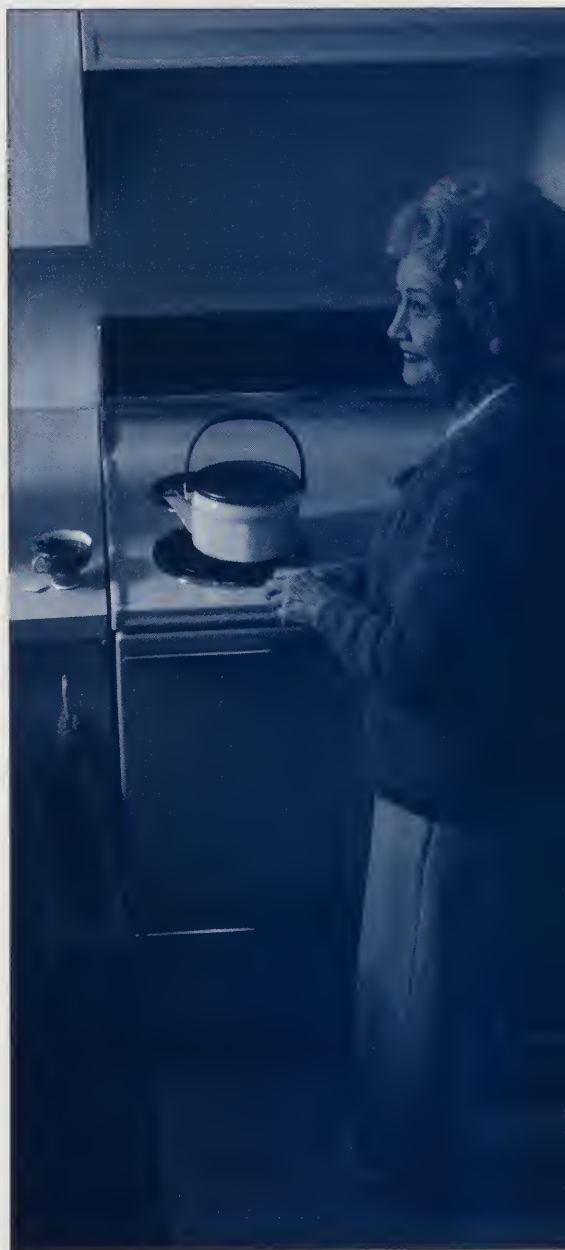
HUNGER HIDES BEHIND MANY FACES

WH SWOLLEN BELLIES AND SAD FACES, IMAGES OF MALNOURISHED CHILDREN FROM UNDERDEVELOPED COUNTRIES ARE ALL TOO FAMILIAR. IN NEW JERSEY, A MORE ECLECTIC SNAPSHOT EXISTS OF THOSE WHO MAY BE SUBJECT TO INADEQUATE DIETS: SENIOR CITIZENS, PEOPLE WITH CHRONIC DISEASES, AND THE POOR.

Phla Smith Noonan

Cases of kwashiorkor, malnutrition stemming from diets severely lacking in protein, are rarely found in developed countries. However, insufficient caloric intake, unbalanced diets, and vitamin deficiencies can contribute to malnutrition in America, says Julie O'Dallivan Maillet, RD, PhD, associate dean for academic affairs in research at UMDNJ-School of Health Related Professions (SRP). "With energy malnutrition, a person isn't taking in enough calories and literally is wasting away. First fat stores are depleted, and then muscles, which includes most major organs, waste away," says Maillet. "When a person reaches 70 percent of their ideal weight, they will die."

Significant weight loss characterizes energy malnutrition, but there are other manifestations as well: diarrhea, dry skin, weakness, increased susceptibility to infection, skin breakdown, lowered blood pressure, reduced heart rate, and below-normal cholesterol levels. Some women may experience amenorrhea or estrogen deficiencies. Low serum albumin levels, while associated with liver disease, reflect protein status in the body and, in turn, could indicate malnourishment. And while it's possible to conduct vitamin assays, says Maillet, "by the time low levels appear in the serum, there's probably been a subclinical deficiency for a while."



Nutrient deficiencies also can have serious consequences. Osteoporosis, associated with inadequate calcium intake, accounts for 1.5 million fractures annually, according to the Osteoporosis and Related Bone Diseases-National Resource Center. Two risk factors for osteoporosis that people can change are eating disorders, such as anorexia and bulimia, and a diet low in calcium and vitamin D.

Malnutrition can result from numerous physical and psychological conditions. "Burn patients have very high caloric needs because of their increased surface exposure, people with Alzheimer's disease may not be eating well, and anytime there's a surgical procedure involving the gastrointestinal system, you have to think about nutritional problems," says Maillet. Cancer patients undergoing chemotherapy often experience taste and smell changes, mouth sores, lack of appetite, nausea, and vomiting that preclude eating as they had before treatment. The key here, she says, is maximizing nutritional intake between sessions and finding foods the patients will eat.

While doctors aren't expected to do a nutritionist's job, notes Maillet, they should be able to screen patients for nutritional risk, make an assessment, reinforce nutritional messages, and know when to refer patients to a registered dietician.

One of several screening tools available is the Nutrition Screening Initiative. Points are assigned to ten statements, such as, "I eat fewer than two full meals per day," and "An ongoing illness or current condition made me change the kind of food I eat."

When UMDNJ-SHRP used this screening tool to assess a group of Newark elderly in the summer of 1997, 40 percent were found to be at moderate risk for inadequate diet, and 36 percent were at high risk.

In a separate study, researchers at UMDNJ-SHRP and the New Jersey Dental School (NJDS) tracked patients who had trouble biting and chewing with full dentures. These patients tended not to use dentures

for eating, lost more weight, and had diets deficient in certain key nutrients, says Riva Touger-Decker, RD, PhD, who teaches at both SHRP and NJDS. One-half of the patients received individual nutritional counseling; the others were given general instructions. "Those who received individual counseling were more likely to use dentures for eating, reported improved eating habits, and had less difficulty biting and chewing," according to Touger-Decker. Following the 1995-1996 study, individualized nutrition education materials were developed for NJDS patients.

That study targeted an easily overlooked cause of nutritionally deficient diets—poor oral health. After loss of more than two molars on one side, chewing—and thus, getting proper nutrition—becomes more difficult. While many people associate tooth decay with tooth loss, periodontal disease accounts for more lost teeth, according to Arthur J. Crosta, DMD, a Lyndhurst dentist. "There's a greater prevalence of periodontitis in patients with poor nutrition, so it can be a vicious cycle," he claims.

Unfortunately, the people with the most tooth loss—generally, the elderly and disadvantaged—often find the cost of bridges, dentures, or implants prohibitive. "Very few dentists take Medicaid patients because

CANCER PATIENTS
UNDERGOING
CHEMOTHERAPY HAVE
EFFECTS THAT
PRECLUDE EATING.

the remuneration to dentists is so small," says Crosta.

While medical or oral health conditions may contribute to nutritionally deficient diets, so can poverty.

"In New Jersey, a person receiving food stamps usually gets less than \$4 a day for food and may be living where there are no cooking facilities," says Debra Palmer Keenan, PhD, nutrition specialist at Rutgers Cooperative Extension in New Brunswick. Two programs she oversees, the federally funded Expanded Food and Nutrition Education Program and the New Jersey Food Stamp Nutrition Education Program, teach poor people nutrition basics, cooking skills, and money management.

"We want to enable lower-income people to get through a month with enough to eat," says Palmer Keenan. "Our goal is food security, which means having nutritionally adequate and safe foods readily available, and that these foods are obtained through socially acceptable ways." Some specialists in this area speak in terms of food security rather than hunger. Hunger is viewed as a condition that over time may lead to malnutrition and that is a potential

SHORT PERIODS OF DEFICIENT DIET CAN AFFECT BEHAVIOR AND COGNITIVE DEVELOPMENT IN CHILDREN.

consequence of food insecurity. According to Tufts University's Center on Hunger, Poverty, and Nutrition Policy, in 1995, 8.7 percent of New Jerseyans were food insecure.

The obstacles poor people face in achieving food security vary. Senior citizens, for example, may be unable to drive to supermarkets and, thus, buy groceries at neighborhood stores with higher prices and limited selections. Younger people may have the transportation but not the know-how when it comes to preparing nutritious meals. For some, it's a matter of changing longstanding habits. "With the food stamp program, we like to see people six times over six weeks. It takes that time for behavior changes to occur," says Palmer Keenan. "But people might attend one or two classes, then find work, and we don't see them again."

Poverty and ignorance can have surprising consequences, such as those people who are overweight and malnourished at the same time.

They may buy food that is both inexpensive and nutritionally lacking. Those who don't have a reliable source of drinking water may find soda to be their cheapest alternative at the store. Children especially are prone to making poor dietary choices, a danger that is compounded when meals at home are sparse.

Malnourished children are a continuing concern. Even short periods of deficient diet can affect their behavior and cognitive development, studies suggest. Yet, while 2,517 New Jersey schools participate in the free or reduced-price lunch program, only 879 schools provide breakfast. "We have a long way to go," says Kathy F. Kuser, director of the state Department of Agriculture's Bureau of Child Nutrition Programs. "Providing the breakfasts is no longer a poor, urban school issue. There's a growing number of single parents and dual earners who are out of the house before their children go to school, and many kids aren't hungry first thing in the morning."

The image of a middle-class, suburban child suffering the effects of a poor diet challenges the stereotypes of what malnutrition looks like—and where it can be found. But that is the nature of malnutrition in America—a health problem that defies economic and demographic boundaries to appear almost anywhere.

Practicing medicine
= good

Practicing running
a business
≠ good

*Practice management and
practice efficiency solutions
from professionals with
hands-on experience*

WITHUM, SMITH & BROWN

Certified Public Accountants & Consultants

Health Services Department

100 Overlook Center

Princeton, NJ 08540

609-520-1188

<http://www.withum.com>

Offices in New Jersey and Pennsylvania



MEMBER NEXIA INTERNATIONAL
A WORLDWIDE NETWORK OF
INDEPENDENT ACCOUNTING FIRMS



*Today, it is not enough to know the latest
technology. Reach over the horizon, and
grasp the technologies that will change
the future...*

***Emerging
Technologies:
New Frontiers in
Medical Rehabilitation
September 25 & 26, 1998***

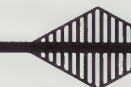
21st Century Medical Rehabilitation
will not just improve function, but will embrace
interventions that reverse the impairments that
underlie chronic disability.

***Transplantation * Telemedicine *
Sensory Rehabilitation * Robotics *
Voice Activated Computers *
The "Smart House" * Neural Prostheses
Virtual Reality *
Complementary & Alternative
Therapies * Pharmacological
Approaches to Brain Damage
Recovery * Neural Regeneration *
and evolutionary developments of
today's technologies and therapies...***

***What is the impact on the patient...
what is the impact on society?***



Mark your calendar today for September
25 & 26, 1998 for ***Emerging Technologies***, at
the Kessler Conference Center, West Orange,
New Jersey. CMEs and CEUs will be
available. Call KMRREC - Kessler Medical
Rehabilitation Research & Education Corporation at 800-
248-3221 (ext. 6812) for a brochure and more
information or visit us at www.kmrrec.org



BREATHING A LITTLE EASIER

A RAPIDLY EXPANDING FIELD, PULMONARY MEDICINE DEMANDS PRACTITIONERS KEEP CURRENT IN SKILL LEVELS AND TRAINING. TUBERCULOSIS, DRUG-RESISTANT ORGANISMS, AND NEW RESPIRATORY PATHOGENS ARE A FEW OF THE AREAS OF NEW AND PROMISING INTEREST.

Moore S. Karetzky, MD

Pulmonary medicine has come a long way since the days of spit and phthisiology. Tuberculosis continues to be an area of concern because of the presence of a susceptible population of immunocompromised patients with AIDS who also serve as a reservoir for further dissemination and the appearance of multidrug-resistant organisms. Similarly, emerging drug resistance of familiar pathogens, such as pneumococcus to penicillin, and new respiratory pathogens, such as cryptosporidia and hantavirus, test pulmonary physicians' clinical acumen

and therapeutic armamentarium of old and new anti-microbial agents such as fourth-generation quinolones, and second-generation carbapenems, and in the clinical testing of Synercid, a new family of antibiotics: the streptogramins.

A chest x-ray, although inexpensive and noninvasive, frequently is equivocal in detecting lung disease including pneumonia. Gallium-67 scintigraphy has been widely used as an imaging technique in *Pneumocystis carinii* pneumonia, neoplasms, sarcoidosis, pneumoconiosis, drug-induced lung toxicity, and idiopathic pulmonary

fibrosis. The application of another nucleide, thallium-201, for the detection of lung disease has several advantages over gallium. Imaging with thallium is completed immediately as opposed to the typical 72-hour delay imposed by gallium between injection and imaging. The lower photon energy exposes the patient and hospital personnel to less radiation and allows subsequent nuclear imaging to be performed immediately, as well as the use of portable cameras, which facilitates its use in an intensive care unit and outpatient setting since injection and imaging are completed concur-



rently. Thallium was found to be more sensitive than gallium in infectious and immune processes in the detection of pneumonia, lung rejection after transplantation, and sarcoidosis. Its use in assessing the response to treatment and as a non-invasive method of diagnosing pulmonary emboli is being evaluated. Just as echocardiography detects right ventricular dysfunction, thallium scanning readily indicates right ventricular dilation and hypertrophy in response to acute or chronic increases in pulmonary vascular resistance as well as its reversibility with thrombolytic therapy. These noninvasive imaging techniques significantly supplement diagnostic capabilities in patients found to have equivocal, low, or intermediate probability V/Q scans.

EMPHYSEMA PNEUMOREDUCTION

Emphysema has been regarded as a diffuse process not amenable to surgical therapy. A limited supply of donor organs makes transplantation a difficult option to offer patients with end-stage chronic obstructive pulmonary disease young enough to qualify for a waiting list. Older or more urgent cases of respiratory failure due to emphysema now are potential candidates for the newly rediscovered limited surgical treatment of lung volume reduction.

Improvement in expiratory flow rates, total lung capacity, residual volume, gas trapping, exercise tolerance, and quality of life have all been reported following pneumoreduction. It is postulated that removing some 10 to 20 percent of overdistended lung allows for better mechanics of the diaphragm and chest wall as well as expansion of undamaged lung units otherwise obliterated by their overdistended neighbors. This, in part, accounts for the immediate postoperative enhancement of gas exchange and exercise tolerance. However, such improvement is not sustained nor has it been shown to prolong life but it serves as a bridge to transplantation for a minority of patients and for a short period of palliation in the others.

We have developed a technique of noninvasive lung reduction utilizing a combination of expiratory maneuvers, a tight-fitting chest cuirass and the further promotion of atelectasis

REMOVAL OF 10-20
PERCENT OF
OVERDISTENDED LUNG
ALLOWS FOR BETTER
MECHANICS OF THE
DIAPHRAGM AND
CHEST WALL.

by having the patient breathe an enriched inspired O₂ mixture. We have been able to achieve a 10 to 20 percent reduction in lung volume by this methodology, but it is not sustained beyond two to three days and requires repeated treatments.

As the technique and protocol develops, it is hoped that just as therapeutic pneumothoraces were performed for tuberculous cavities in the past, periodic volume reductions will prove to be a similarly effective mode of physical therapy. This is a nonsurgical outpatient office procedure and, potentially, a daily maneuver carried out at home in addition to current routine inhalation bronchodilator regimens.

OBSTRUCTIVE SLEEP APNEA

There is an association of right ventricular, and to a lesser extent left ventricular, dysfunction with obstructive sleep apnea (OSA), which is reversible with treatment. An association of OSA with hypertension and stroke also has been demonstrated indicating the potentially severe cardiovascular morbidity of OSA. A seven-year followup on patients diagnosed with OSA showed the benefits of treatment

and the increased morbidity and mortality of patients who did not tolerate or follow the prescribed treatment of nasal CPAP. There was less than a 50 percent satisfactory adherence. Educational activity must accompany treatment and the understanding of risk is crucial to obtain a good adherence; it works better than symptom relief.

We also have investigated the prevalence of OSA in patients admitted to the medical intensive care unit with cardiovascular events. Patients with hypertensive urgency, stroke, and congestive heart failure had a 67 percent prevalence of OSA. If such a diagnosis is suspected, early intervention may reduce hospital morbidity and mortality as well as increase long-term survival and facilitate subsequent management.

It is of interest that the incidence of rhinitis is increased in OSA and a pilot project evaluating patients with allergic rhinitis indicated that some patients with associated sleep disordered breathing experienced significant improvement in their quality of sleep with antihistamine treatment.



Monroe Karetzky, MD

ACUTE LUNG INJURY SYNDROME

Participation in pharmaceutical company-sponsored multicenter trials for drugs in the treatment of sepsis and the acute lung injury syndrome has led us from one unsuccessful thesis to another. Trials were given for the administration of endotoxin antibodies, proinflammatory cytokine antagonists, and soluble receptors as well as a liposome carrier to facilitate intracellular penetration of an antiinflammatory. All eventually proved ineffectual after promising beginnings. This uniform history of failure has been attributed to the multiplicity of mediators involved in the inflammatory cascade neutralizing the effect of a single therapeutic agent. Currently, other approaches are being pursued, such as using recombinant activated protein C (rAPC) and antithrombin III to impair the coagulation cascade that is thought to play a role in endothelial activa-

tion that leads to the occlusion of the microvasculature in sepsis. Studies also are pursuing the use of granulocyte-macrophage colony stimulating factor to enhance the bodies polymorphonuclear leukocyte (PMN) response to pneumonia, as well as the administration of antioxidants and antagonists of nitrous oxide formation in sepsis.

Experience with peripartum respiratory failure due to the acute lung injury syndrome has indicated that amniotic fluid emboli was not an uncommon event. However, rather than invariably being particulate and near-fatal in nature, it usually is due to a soluble mediator normally contained in the amniotic fluid that gains access to the maternal circulation ("leaks") in a variety of predisposing conditions complicating pregnancy, including infection, twin pregnancy, and C-section. Further, it was suggested that platelet activating factor (PAF) was a likely agent. PAF actually is a family of structurally related letter-linked phospholipids possessing many of the properties of a potent proinflammatory mediator and is in very high concentration in the amniotic fluid.

Dr. Karetzky is affiliated with Newark Beth Israel Medical Center and is a member of the MSNJ Council on Communications.

Our medical specialists make a practice of creating solutions for physicians like you.

Summit Bank's Healthcare Financial Services Group features some of the finest medical specialists in New Jersey. They understand your industry and the issues facing it. As New Jersey's largest locally headquartered bank, our professionals are specifically devoted to the healthcare industry. That means our customized solutions — from loans to leases — come with something extra: time-tested expertise. If you'd like, we'll even help you find a more efficient way to run your practice. To find out more, call Norm Buttaci, Regional Vice President, 609-987-3561.



Summit, Summit Bancorp and Reach Higher are registered service marks of Summit Bancorp • Summit Bank is a service mark of Summit Bancorp.



GENITAL PROLAPSE

WOMEN WITH GENITAL PROLAPSE EXHIBIT A PLETHORA OF LOWER URINARY TRACT SYMPTOMS, INCLUDING URINARY FREQUENCY, URGENCY, INCONTINENCE, HESITANCY, AND INCOMPLETE EMPTYING. THESE SYMPTOMS MAY BE RELATED TO PROLAPSE,

YET CAREFUL CLINICAL AND URODYNAMIC INVESTIGATION CAN DETERMINE THE UNDERLYING PATHOPHYSIOLOGY WITH A HIGH DEGREE OF ACCURACY.

David C. Chaikin, MD; Jerry G. Blaivas, MD

Genital prolapse is an abnormal descent of the pelvic viscera. The etiology often is multifaceted. Most commonly, it is a result of childbirth (with its attendant neurologic and structural consequences), the upright position and trophic changes of the vaginal supporting structures. It also can be a result of trauma or previous pelvic surgery. Damage to these structures may lead to prolapsed bladder (cystocele), rectum (rectocele), peritoneum and intestines (enterocele), or uterus.

Support to the bladder, uterus, and rectum is provided by the levator ani musculofascial complex. Individual condensations of these muscles and fascia have been the subject of an extensive lexicon of near synonyms.

Support of the bladder and urethra has been called the pubourethral ligament, urethropelvic ligament, vesicopelvic fascia, periurethral fascia, pubocervical fascia, endopelvic fascia, arcus tendineus fascia pelvis, and arcus tendineus musculii levator ani. Uterine support is provided by the cardinal and uterosacral ligaments and rectal support by the prerectal fascia, the pararectal fascia, and the perineal body and its muscles.¹⁻⁵

Musculofascial support is structured like a hammock attached to the lateral pelvic sidewalls (arcus tendineus). To better visualize how this works, put your hands together in your lap, palms up and fingers interlocking. Put your two thumbs together to form an upside down V. Your palms and fingers represent the

pelvic floor muscles. The bladder rests on these muscles and the urethra goes through the arch of the upside down V. Attenuation of support of the bladder at the pelvic side wall results in a lateral cystocele defect (70 to 80 percent), while attenuation of the central support results in a central defect (5 to 15 percent).⁶

An enterocele is a herniation of the peritoneum with or without bowel contents. Although an enterocele can occur without a history of previous surgery (traction enterocele), it usually occurs in women who have had a previous hysterectomy (pulsion enterocele). A traction enterocele usually is associated with uterine prolapse and protrudes posterior to the uterus, extending into

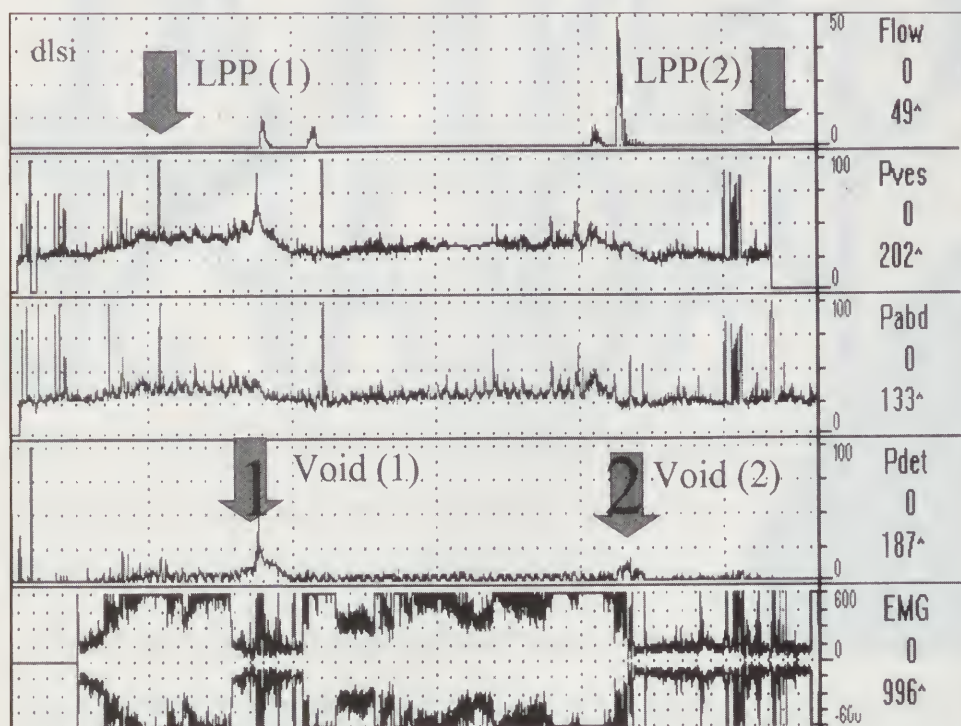


Figure 1. Urodynamic tracing. With 150 ml in the bladder and the cystocele protruding, a leak point pressure was obtained at the arrow marked LLP 1. There was no leakage despite a cough to over 100 cm H₂O. At the arrow marked void 1, the patient voided with a Q_{max}=12 ml/s and a p_{det}Q_{max}=50 cm H₂O, which indicates urethral obstruction. With 150 ml in the bladder and the cystocele reduced with a ring pessary, the leak point pressure was repeated at the arrow marked LLP 2. There was leakage at a LPP=52 cm H₂O. At the arrow marked void 2 the patient voided with a Q_{max}=49 ml/s and a p_{det}Q_{max}=18 cm H₂O, which indicates a "super" normal uraflow and no obstruction.

the rectouterine space. Rarely, there may be an enterocele that protrudes anterior to the uterus (anterior enterocele). A pulsion enterocele protrudes from the apex of the vagina and usually is the result of damage to the cardinal-uterosacral ligament complex from a hysterectomy. A rectocele occurs as a consequence of weakening of both the supporting pararectal and prerectal fascia as well as laxity of the perineum.

PROLAPSE & MICTURITION

Genital prolapse can affect the urethra in three ways. The prolapse itself can mechanically obstruct the urethra; it can pull open the posterior wall of the urethra and thereby

cause sphincteric incontinence or, from a functional viewpoint, it may dissipate the effects of abdominal pressure on the urethra. The functional consequences of prolapse are that it may impede valsalva voiding, mask sphincteric incontinence, and

THE UROLOGIC EVALUATION OF WOMEN WITH GENITAL PROLAPSE COMMENCES WITH A FOCUSED HISTORY AND EXAMINATION.

mask incontinence due to detrusor overactivity. Further, by an unknown mechanism, prolapse may be associated with detrusor instability.

Not all lower urinary tract symptoms (LUTS) in women with prolapse are due to the prolapse. Other common causes include urinary tract infection, detrusor instability, impaired detrusor contractility, bladder outlet obstruction, polyuria, and sensory urgency.

EVALUATION

The urologic evaluation of women with genital prolapse commences with a focused history and examination. The history should note the frequency and severity of each symptom.

In particular, the examiner should carefully elicit problems with stress and urge incontinence. It is difficult for the patient and the physician to make the distinction between the two. Urge incontinence is defined as urinary leakage accompanied by a sudden, precipitous, and uncontrollable urge to void. Sometimes a severe urge to void is described as being painful. The underlying cause of urgency and urge incontinence is presumed to be detrusor overactivity. Sphincteric incontinence is urinary loss due to sphincter weakness and is typically demonstrable as incontinence, which occurs during episodes of increased abdominal

pressure, e.g. cough or strain, in the absence of detrusor overactivity. Pregnancy history, menstrual status, e.g. menstruating, peri- or postmenopausal, prior pelvic surgery, medical conditions, and current medications are reviewed with a focus on impact on lower urinary tract function.

An important part of the evaluation of LUTS in women with genital prolapse is the voiding diary and pad test. The diary records the time and amount of each urination and a description of each symptom. The pad test provides an objective measure of the amount of urinary loss. These instruments are reproducible, permitting comparison of actual recorded and measured leakage with patient subjective quality of life impact ratings. These tools often help patient and physician delineate predominant mechanisms in women with mixed urinary incontinence symptoms.

PHYSICAL EXAMINATION

Examination should be performed with the bladder full (to assess the degree of prolapse and stress incontinence) and empty (to assess uterine size and consistency and pelvic masses). If the full extent of prolapse is not obvious in the lithotomy position, the examination should be repeated with the patient standing. With a comfortably full bladder, the patient is asked to

THE EVALUATION OF LOWER URINARY TRACT SYMPTOMS IN WOMEN WITH GENITAL PROLAPSE INCLUDES THE VOIDING DIARY AND PAD TEST.

cough or strain with increasing degrees of force. A simple classification describes the prolapse in relation to the hymenal ring. In grade 1, the inferior margin of the descent is above and in grade 2, at the hymenal ring. Grade 3 protrudes beyond the ring and grade 4 is well beyond it.⁷ For women with cystocele, the examiner also should identify the primary defect causing the prolapse (central, lateral, combined). Examination with a half-speculum or a tongue blade facilitates this distinction. With the half-speculum gently depressing the posterior vaginal wall, the patient is asked to strain. Pure lateral defects allow the bladder/anterior vaginal wall to descend with preservation of transverse vaginal rugation. One can confirm this by supporting the lateral vaginal fornices and repeating the straining. If lateral support prevents cystocele descent, an isolated paravaginal (or lateral defect) cystocele is present. With central defects, the anterior vaginal wall is smooth, and with straining, the bladder descends through an obvious dependent hernia defect. Lateral vaginal support does not reduce the defect.

If incontinence is not demonstrated initially, the cystocele or other significant prolapse is reduced mechanically (pessary or split speculum) and stress maneuvers repeated, which often can unmask stress incontinence. If incontinence is not demonstrated in the lithotomy position, the examination is repeated in the standing position. The patient stands in front of the examiner with one foot elevated on a short stool and again asked to cough and strain, with mechanical reduction of severe prolapse as indicated.

Vaginal muscle strength is assessed by inserting two fingers in the vagina while the patient is asked to "squeeze" as if holding in urine or rectal gas. Overall strength, duration of contraction in seconds, and anterior displacement are assessed. Following vaginal examination, rectal examination should be performed with one finger of the examiner in the rectum and one in the vagina. The patient is asked to strain and then contract the rectal sphincter, allowing the clinician to identify rectal prolapse, distinguish rectocele from enterocele, and evaluate external anal and sphincter strength. Rectovaginal examination also should be repeated in a standing position, if needed.

Patients who present for evaluation with a pessary in place are examined both with and without the pessary in the vagina. With the pessary in place, patients are checked for stress incontinence with a full bladder as described. Degree of prolapse is evaluated with pessary removed. Often patients with significant prolapse have seemingly good support

even after many hours without pessary support. In such a woman, it may be advisable to remove the pessary and ask her to return after the prolapse descends in the normal course of her daily activities. The vagina is examined for any erosions or pudendal nerve injury from an ill-fitting pessary. Pudendal nerve injury is associated with paravaginal and perianal anesthesia, absence of the bulbocavernosus reflex, decreased anal sphincter tone, and worsening prolapse.

A screening neurologic examination is part of a complete evaluation of LUTS and includes cognitive, motor, and sensory functioning. Of particular importance is evaluation of the sacral dermatomes (anal sphincter tone and control, perianal sensation, and the bulbocavernosus reflex).

URODYNAMIC EVALUATION

The purpose of the urodynamic evaluation in women with genital prolapse is to determine the precise etiology of the patient's incontinence when part of the symptom complex; to "unmask" occult incontinence in women with no incontinence symptoms; to evaluate detrusor function (impaired detrusor contractility, detrusor overactivity); to deter-

mine the degree of pelvic floor prolapse; and to identify urodynamic risk factors for the development of upper tract obstructive nephropathy.

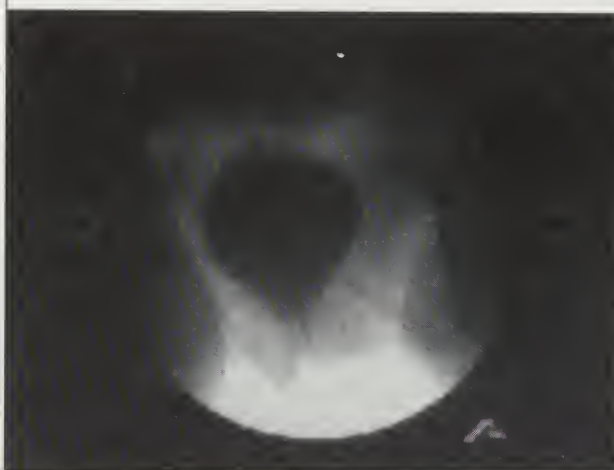
Urodynamic techniques range from simple "eyeball urodynamics" to sophisticated multichannel synchronous video/pressure flow/EMG studies. We believe that synchronous multichannel videourodynamics offers the most comprehensive, artifact-free means of arriving at a precise diagnosis. If videourodynamics is not available, then a lateral voiding cystourethrogram along with pressure flow urodynamics can be done. The voiding cystourethrogram affords the opportunity to evaluate the size of the cystocele, which often is much larger in the standing position as compared to the lithotomy position, as well as directly assessing urethral sphincter integrity. The cystourethrogram also can identify any pathology (retained suture with stone, diverticulum) that may have been a result of previous vaginal or bladder surgery.

In women with genital prolapse, we perform two urodynamic studies:

the first without any reduction of prolapse and the second with the prolapse reduced with a ring pessary (Figures 1, 2, and 3). We believe this is the best way to afford support to the prolapse to "mimic" surgical correction. Alternatively, reduction of pelvic prolapse can be done with a Sims speculum or a vaginal pack.

Among urodynamicists, the concern has been raised that pessary reduction may cause artifactual urethral obstruction. To examine this possibility, we evaluated 60 women who had genital prolapse with LUTS and/or incontinence with videourodynamics to assess the effects of prolapse on micturition. The women were divided into two groups based on the degree of descent: small cystocele (grade 1 or 2) and large cystocele (grade 3 or 4). Pressure-flow analysis, leak point pressure, and free flow were measured in all women. Women in the severe group also underwent repeat free flow analysis and leak point pressure determination with mechanical reduction of their cystocele with a ring pessary.

Figure 2. Cystogram obtained at LPP 1 showing the cystocele protruding.



Urodynamic data were sorted according to presence or absence of bladder outlet obstruction, impaired detrusor contractility, detrusor instability, and stress incontinence. As there are no standardized urodynamic definitions for bladder outlet obstruction or impaired detrusor contractility in women, we elected to define this condi-

tion: Women with maximum detrusor pressure (Pdet) greater than 20 cm H₂O with maximum flow (Q_{max}) less than 12 ml/second were classified as having bladder outlet obstruction. Women with Pdet less than 15 cm H₂O with Q_{max} less than 12 ml/second were classified as having impaired detrusor contractility.

Women with large cystoceles (grade 3-4) were much more likely to be obstructed on urodynamics (72 percent) than women with small ones (grade 1-2) (6 percent) ($P < .05$). Following pessary placement, 91 percent of those with large cystoceles and obstruction had normal free flowmetry, presumably because the prolapse itself was causing obstruction, which was relieved after reduction. Of the 25 women with large cystoceles, 80 percent had occult stress incontinence. Following pessary placement, all patients had a significant decrease in their leak point pressure. We believe the profound reduction in leak point pressure after pessary placement in this series speaks against the pessary as an inadvertent cause of urethral obstruction.

Urethral hypermobility had no significant distribution between those with various grades of stress incontinence and those with no uri-

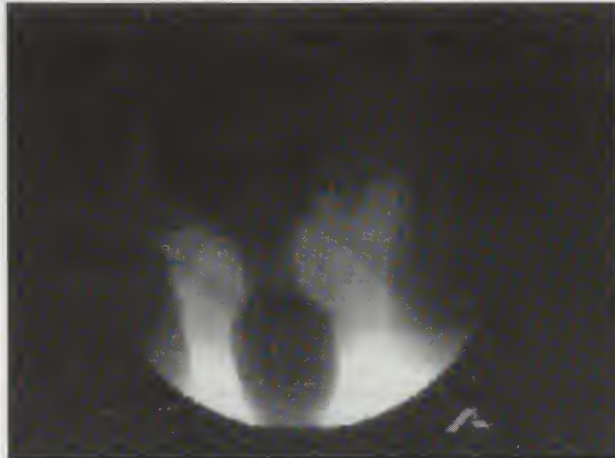


Figure 3. Cystogram obtained at LPP 2 showing the cystocele reduced by a ring pessary.

nary incontinence at all. Classically, urethral mobility is used to differentiate type II stress incontinence from type III (intrinsic sphincter deficiency). In this series, urethral hypermobility was present in 59 percent of those with intrinsic sphincter deficiency (as defined by a VLPP less than 60cm H₂O), confirming the need for careful evaluation of all incontinent women with emphasis placed on urethral function, rather than the presence or absence of periurethral support, which may or may not be an isolated cause of stress incontinence.⁸

Our study confirms the findings of other investigators and highlights the need to evaluate for the presence of urethral obstruction and occult stress incontinence in all women with prolapse, regardless of the symptom history.⁹⁻¹⁶ It is clear from this and other studies that reduction of genital prolapse during urodynamic evaluation is a valuable aid in unmasking occult stress incontinence.

Determining the necessity of a concomitant incontinence proce-

dures at the time of prolapse repair is controversial, in that some investigators believe all severe prolapse patients are best served by concomitant procedures regardless of preoperative continence status, while others (ourselves included) believe individual selection based on urodynamic data is optimal. Bergman utilized urodynamics to select prolapse patients for concomitant

incontinence surgery. Those with no stress incontinence on preoperative testing underwent prolapse repair alone, and those with stress incontinence underwent prolapse repair and urethropexy. Those with severe prolapse were evaluated with pessary reduction of the prolapse, and only patients with urethral pressure profiles consistent with stress incontinence underwent concomitant urethropexy.¹⁷ All patients in this series were continent postoperatively. Other researchers have begun performing concomitant anti-incontinence procedures on all patients with severe prolapse, regardless of their preoperative continence status. McGuire reported 89 percent continence rates in a group of continent and incontinent women with severe genital prolapse, all of whom underwent surgical reduction and concomitant pubovaginal sling.¹⁸ Similar outcomes were reported by Raz on 46 women with severe prolapse (not all of whom demonstrated stress incontinence on preoperative urodynamics), 26 (57 percent) of whom had urethral

hypermobility but no stress incontinence symptoms prior to surgery.¹⁹ While such prophylactic incontinence procedures on continent women with prolapse may be routine in some centers, we believe the decision to perform concomitant urethropexy or sling on any women with severe genital prolapse should be based on urodynamic findings both with and without ring pessary prolapse reduction.

CONCLUSION

Concomitant genital prolapse, voiding dysfunction, and incontinence are common reasons for women to seek urologic care. We believe treatment of these women should be directed at specific pathophysiology. Directed history and physical examination, diary, pad test, and cystometric testing are key components of a comprehensive evaluation.

Dr. Chaikin is affiliated with Morristown Memorial Hospital and Cornell Medical Center/New York Hospital and Dr. Blaivas is affiliated with Cornell Medical Center/New York Hospital.

REFERENCES

1. Mostwin JL: Current concepts of female pelvic anatomy and physiology. *Urol Clin NA* 175-195, 1991.
2. Wahle GR, Young GP, Raz S: Anatomy and pathophysiology of pelvic support, in Raz S, *Female Urology*. Philadelphia, PA, WB Saunders, 1996.
3. Delancey JOL: Correlative study of paraurethral anatomy. *Obstet Gynecol* 68:91-97, 1986.

4. Delancey JOL: Structural aspects of the extrinsic continence mechanism. *Obstet Gynecol* 72:296-301, 1988.

5. Delancey JOL: Pubovesical ligament: A separate structure from urethral supports ("pubourethral ligaments"). *Neurol Urodyn* 8:53-62, 1989.

6. Macer G: Transabdominal repair of cystocele, a 20-year experience compared with the traditional vaginal approach. *Am J Obstet Gynecol* 131:203, 1978.

7. Baden WF, Walker TA: Physical diagnosis in the evaluation of vaginal relaxation. *Clin Obstet Gynecol* 15:1060-1065, 1972.

8. Chaikin DC, Romanzi L, Blaivas JG: Unpublished data, 1988.

9. Arnold EP, et al.: Urodynamics of female incontinence: Factors influencing the results of surgery. *Am J Obstet Gynecol* 117:805-813, 1973.

10. Richardson DA, Bent AE, Ostergard DR: The effect of uterovaginal prolapse on urethrovesical pressure dynamics. *Am J Obstet Gynecol* 146:901-905, 1983

11. Bump RC, Fantl JA, Hurt WG: The mechanism of urinary continence in women with severe

uterovaginal prolapse: Results of barrier studies. *Obstet Gynecol* 72:291-295, 1988.

12. Rosenzweig BA, Pushkin S, Blumenfeld D, Bhatia NN: Prevalence of abnormal urodynamic test results in continent women with severe genitourinary prolapse. *Obstet Gynecol* 79:539-542, 1992.

13. Fianu S, Kjaeldgaard A, Larson B: Preoperative screening for latent stress incontinence in women with cystocele. *Neurol Urodyn* 4:3-7, 1985.

14. Ghoneim GM, Walters F, Lewis V: The value of the vaginal pack test in large cystoceles. *J Urol* 152:931-934, 1993.

15. Mattox TF, Bhatia NN: Urodynamic effects of reducing devices in women with genital prolapse. *Int Urogynecol J* 5:283-286, 1994.

16. Coates KW, Harris RL, Cundiff GW, Bump RC: Uroflowmetry in women with urinary incontinence and pelvic organ prolapse. *Br J Urol* 80:217-221, 1997.

17. Bergman A, Kooning PP, Ballard CA: Predicting postoperative urinary incontinence development in women undergoing operation for genitourinary prolapse. *Am J Obstet Gynecol* 158:1171-1175, 1988.

18. Cross CA, Cespedes DR, McGuire EJ: Treatment results using pubovaginal slings in patients with large cystoceles and stress incontinence. *J Urol* 158:431-434, 1997.

19. Raz S, Little NA, Juma S, Sussman EM: Repair of severe anterior vaginal wall prolapse (grade 4 cystourethrocele). *J Urol* 146:988, 1991.

CAREFUL URODYNAMIC
INVESTIGATION
CAN DETERMINE
PATHOPHYSIOLOGY OF
GENITAL PROLAPSE.

THE SURVIVAL CHAIN CPR, ASAP

MEDICAL EMERGENCY, EVERY
SECOND COUNTS. AND, WHILE
PULMONARY RESUSCITATION
(CPR) IS ESSENTIAL TO LIFESAVING,
THERE ARE THREE OTHER ASPECTS OF
ITS IMPORTANCE: EARLY ACCESS,
EARLY DEFIBRILLATION, AND EARLY
ADVANCED CARE.

Don Rapport

For every minute of delaying appropriate emergency care including CPR and defibrillation, the chances of a person's survival decrease by 10 percent," warns Kevin Sorge, emergency cardiovascular care district manager of the American Heart Association (AHA) in North Brunswick. "That leaves little time for error or delay." In a medical emergency, when every second counts, cautions Sorge, "Laypeople need better information and training on what to do. And while medical professionals are well trained, many times they, too, are in need of



The Summit First Aid Squad responds to a medical emergency.

current information, refresher courses, and revised state guidelines."

Many people wrongly believe that CPR, alone, will save their loved ones in an emergency. "Once the realm of emergency physicians, cardiologists, and critical care doctors, the vast majority of people are unfamiliar with CPR or emergency procedures," reports Alfred Sacchetti, MD, associate director, Department of Emergency Medicine, Our Lady of Lourdes Medical Center. "While knowing CPR is very important, the

vital aspect of resuscitation is response time. The actual lifesaving component in cardiac arrest is getting a defibrillator to the scene, and fast. Even under the best circumstances, if defibrillation is done within 11 minutes, the odds of a successful outcome are less than 10 percent."

Experts from the AHA agree; according to the AHA's new guidelines for basic life support, four components must be present to improve survival chances significantly: early access, early CPR, early defibrillation, and

early advanced care. "These components are called the 'chain of survival.' If any single component fails, a person's chances fail," notes Sorge.

"Prevention remains the best cure. However, even the best preventive care cannot eliminate all emergencies," notes Lupe Gonzales, Jr., of the American College of Emergency Physicians (ACEP), a national medical society representing 19,000 physicians who specialize in emergency medicine. ACEP recommends that physicians review the following emergency warning signs with their patients and their family members: difficulty breathing or shortness of breath, chest or upper abdominal pain or pressure, fainting, sudden dizziness, weakness or change in vision, confusion or change in mental status, sudden severe pain, bleeding that won't stop, severe or persistent vomiting, coughing up or vomiting blood, or suicidal or homicidal feelings.

Sacchetti stresses that physicians should urge patients with heart disease to take any warning sign seriously, including feelings of indigestion, lightheadedness, or dizziness. "People with heart disease should be educated about early symptoms. Their families should take basic life support classes, and they should not hesitate to call 9-1-1 if symptoms occur."

In New Jersey, and in other areas with a 9-1-1 emergency number, calling for help is easy: however,

while 75 percent of Americans live in an area with 9-1-1 service, less than one-third of the country's geographic area is covered. Patients, especially those with medical risks and young children, should be reminded to check the local emergency medical services (EMS) number, even while travelling. In addition, the EMS number should be posted by the telephone, and children should be taught how to call for emergency help from home and from a pay telephone.

Dialing 9-1-1 will connect the caller to EMS, a team of professionals trained to handle medical, fire, rescue, and other emergency situations. The team includes dispatch operators, emergency medical technicians (EMTs), paramedics, firefighters, police, emergency nurses, and physicians. Paramedics and EMTs are trained to begin medical treatment on the way to the hospital, and to alert a hospital emergency department of the patient's condition in advance.

Emergency medicine physician Alfred Sacchetti, MD, reviews important life-saving information with a patient in the ER.



CPR is the basic lifesaving technique used when breathing stops and/or the heart stops beating. "The timely application of CPR has been credited with helping save thousands of lives each year in the United States," reports Kelly Alexander of the American Red Cross.

In households with infants and children, CPR may be needed because of suffocation caused by choking, smoke inhalation, sudden infant death syndrome (SIDS), accidents, or drowning. In adults, CPR primarily is needed due to heart attacks. The newest AHA guidelines recommend that people call EMS or the equivalent before beginning CPR on adults, and after one minute of CPR on children. "When there are two people present, one should make the call while the other begins CPR. People shouldn't be afraid of doing CPR incorrectly. Doing something is better than doing nothing," urges David Novak, director of communications, New Jersey Capital Area Chapter, American Red Cross.

Basic life support classes, which include CPR, are given in many New Jersey hospitals and schools. Last year, the AHA trained over 191,000 people in New Jersey. Throughout the nation, over five million people receive CPR training each year from

instructors taught by the American Red Cross or AHA. "While this may seem like a lot, it is a fraction of the population. More people need training. In a time of crisis, panic can worsen a situation. Our courses teach people how to deal with a crisis situation, so response is 'routine' and not made in panic. Certificates are good between two and three years. People need to go back and get recertified to keep up their skills," says Novak. Laymen and physicians, alike, need to keep abreast of the latest emergency guidelines.

There is a four-minute time gap between the heart stopping and the brain starting to die from lack of oxygen-rich blood. CPR can help support a life until emergency help arrives. It boosts a heart attack victim's chance of survival, gives the victim a better chance of surviving without extensive brain damage from lack of oxygen, and helps prevent organ damage until a defibrillator gets there.

"When the heart is in ventricular fibrillation, and stops beating normally, the way to get it back is through shocking it by defibrillation," says Sorge. During ventricular fibrillation, little or no blood is pumped from the heart. Collapse and sudden death will follow within

THE LIFESAVING COMPONENT IN CARDIAC ARREST IS GETTING A DEFIBRILLATOR TO THE SCENE—AND FAST.

minutes unless help is provided immediately. Fortunately, New Jersey is one of the more progressive states when it comes to emergency defibrillation. Recently, the state passed the First Responder Bill, which permits police officers or other on-site emergency people to administer defibrillation, when necessary.

Often, police officers are the first to arrive at an emergency. With the advent and availability of high-quality, automated external defibrillators (AEDs), specifically designed for use by people without a medical background, lives will be saved. The AED is a portable defibrillator that automatically accesses the situation by analyzing heart rhythms of the victim. It administers shocks only if the victim is in ventricular fibrillation.

Although the law permits use of defibrillation for first responders, it does not require it or fund it. "Only a small number of police departments are using this equipment. It is crucial to get these machines where

it is important to the survival chain," urges Sorge.

Families of high-risk heart patients also should consider purchasing an automatic defibrillator for home use, since 70 percent of heart attacks occur at home. Corporations and businesses should consider having one on the premises for emergency use, as well. AEDs are available for about \$4,000, but a model under \$1,000 will be available soon.

Optimally, this final link of the survival chain should be in place within six to eight minutes. Additional medical care should have arrived, airways should have been opened, defibrillation initiated, drug therapy begun, and the patient stabilized. At this point, the patient should be on the way to or already at the hospital for additional care.

"The American Red Cross (ARC) encourages physicians to explain early access and intervention to their patients," notes Kelly Alexander of ARC. "The basic principle is to bring rapid medical care to the victim. This includes recognition of emergency and initial care provided by the citizen responder, early activation of the EMS system, first responder care, EMT care, hospital care, and rehabilitation."

Early arrival of emergency personnel increases a victim's chances of surviving a life-threatening emergency. Calling the emergency number is the most important action a person can take. ■

Medical Society of New Jersey

Long Term Care Insurance Program

Ensuring a Secure Future by Preserving Assets

As medical professionals, you know first hand the devastating effects that extended long term care can have on a person's hard earned assets. The cost of nursing home stays can range from \$3,000-\$5,000 per month. The Medical Society of New Jersey endorses The Travelers and CNA Insurance Companies' policies to help you guard against unforeseen tragedies. Through a special arrangement with The Travelers and CNA Insurance Companies, members, spouses, parents and in-laws are eligible for a premium reduction.

IMPORTANT FEATURES OF THE MSNJ ENDORSED LONG TERM CARE INSURANCE PROGRAM

- ◆ Available Ages 45-84
- ◆ Specialty Plans Available Ages 80-100
- ◆ Benefits up to \$250/day
- ◆ No prior hospitalization required
- ◆ Several waiting periods
- ◆ Alzheimer's, senility covered
- ◆ Lifetime benefits available
- ◆ Guaranteed renewable for life
- ◆ Coverage for custodial, skilled and intermediate care as well as adult day care
- ◆ Available to your spouse, parents and in-laws
- ◆ Waiver of premium benefit
- ◆ Inflation protection available

DISCOUNT FOR MEMBERS OF MSNJ, SPOUSES, PARENTS AND IN-LAWS

For more information, please call

DONALD F. SMITH & ASSOCIATES

A division of THE COPELAND COMPANIES'

Two Tower Center, P.O. Box 1063
East Brunswick, New Jersey 08816-1063

(888) 297-7225

Copeland Associates, Inc.

Medical Society
MSNJ

P

RIMARY CARE PHYSICIANS MUST ASSESS A CHILD'S RISK OF LEAD EXPOSURE

ANNUALLY FROM SIX MONTHS UNTIL SIX YEARS OF AGE. A PHYSICIAN

EDUCATION INITIATIVE REPORTS ON THE RESULTS OF PHYSICIAN KNOWLEDGE AND

PRACTICE PRIOR TO THE NEW LEAD LAW IN NEW JERSEY AND ITS IMPLICATIONS.

Getting the Lead Out

*Karen Denard Goldman, PhD; Dana Ostrow; Antonia Iy, MD;
George G. Rhoads, MD, MPH*

Lead poisoning (plumbism) is the number one preventable environmental disease affecting the health and development of young children in the United States today.¹ Lead contamination from past use of leaded gasoline, from deteriorating lead-based paint, from lead-contaminated water tanks and pipes, and from contamination of the food chain has led to especially severe multi-route exposure problems. The most pernicious and pervasive risk factors are lead-based paint chips and

dust, lead-contaminated soil, and drinking and cooking water contaminated by lead in the plumbing found in many old homes and apartments.

Blood lead levels as low as 10 µg/dL are known to cause neurologic and cognitive deficits. Lead serves no useful purpose in a child's body and becomes increasingly harmful as it accumulates, triggering a broad spectrum of dysfunctional behavioral and neurologic consequences.²⁻⁹ Studies show that even low or moderate levels of lead in the blood cause significant

LEAD POISONING IS THE
NUMBER ONE PREVENTABLE
ENVIRONMENTAL DISEASE
AFFECTING THE HEALTH
OF YOUNG CHILDREN.

damage. Acute lead poisoning in children has resulted in irreversible brain damage, behavioral impairment, coma, convulsions, and death. Children exposed to even low levels of lead poisoning may experience a subtle but irreversible loss of intelligence, negative behavior change, and poor school performance. Youngsters with high lead levels seem less able to perform rapid, highly coordinated hand movements.

CHILDHOOD LEAD

Childhood lead screening is a highly charged topic, triggering much debate among New Jersey physicians, public health workers, parents, and consumer and child health activists in both the inner cities and rural areas of the state. As a result of this debate, the New Jersey Physician Lead Advisory Committee (NJPLAC) was organized in 1992 to provide the New Jersey Department of Health and Senior Services (DHSS) and the state medical community with local leadership and expertise on lead screening and the clinical management of lead poisoning. NJPLAC was created to establish a standard of care for diagnosis and treatment of childhood lead poisoning in New Jersey; to act as a resource to the health commissioner and the Childhood Lead Poisoning Prevention Program; to provide feedback on state and national lead screening and lead poisoning treatment practices of New Jersey physicians; to respond to national initiatives such as the 1991 CDC recommendations; to communicate standards established by the committee to the medical community; to advocate for appropriate screening and followup; and to provide consultation and act as mentors to physicians unfamiliar with childhood lead poisoning. Within two years, NJPLAC published *Guidelines for Screening and Followup*. In 1994, to promote screening, the committee launched the Physician Lead Education Initiative, a series of three

regional presentations and four grand rounds.

Though New Jersey has a number of stereotypical lead "hotbeds" (old and deteriorating housing stock in formerly industrial inner cities), 1995 and 1996 DHSS data indicate that children with elevated

blood lead levels (≥ 20 $\mu\text{g/dL}$) were found in all 21 counties. However, childhood lead screening in the state is not universal.

In January 1996, Governor Whitman signed into law an act (PL 1995 C. 328) requiring universal childhood lead screening in New Jersey. New Jersey, thus, became the fifth state in the nation to require universal childhood lead screening.

New CDC revised childhood lead screening guidelines, published in November 1997, recommend that a screening policy be determined by state or local health departments based on local risk factors and childhood lead poisoning prevalence rates. Universal screening was recommended for areas with either a prevalence of one- to two-year-old children with blood lead levels over 10 $\mu\text{g/dL}$ or with 27 percent or more of their housing stock built before 1950. According to the U.S. Census, over 35 percent of New Jersey's housing stock was built before 1950.¹³ In addition, there is no data on the percentage of children in New Jersey with blood lead levels over 10 $\mu\text{g/dL}$, because only elevated (≥ 20 $\mu\text{g/dL}$) blood levels were reportable. According to the new CDC guidelines, universal screening is recommended for the state. Thus, the new New Jersey lead screening law was passed earlier than, and independent of, the national guidelines, but it is consistent with the 1997 CDC recommendations.¹⁴

In 1996, NJPLAC conducted a statewide survey of physicians to assess current practices and compliance with current CDC risk assessment, screening, and treatment recommendations. Results of the cross-sectional survey of 541 randomly selected pediatricians and fami-

ly practitioners showed that risk assessment, screening, appropriate medical followup, and parent education have not become standard practice.¹⁵ Most physicians reported that they would confirm blood lead elevations, institute individual case management, and treat as a medical emergency lower blood lead levels than those recommended by CDC. Most practitioners were not educating parents about lead exposure ($P<.05$). Among all respondents, 42.8 percent ask fewer than one-half of their patients' parents risk assessment questions. About 32 percent were not screening infants, 23 percent were not screening children between one and two years, and 31 percent were not screening children between two and six years. Only 42 percent of pediatricians and 24 percent of family practitioners stated that more than three-quarters of the children in their practice were screened by age two. In addition, 15 and 32 percent of pediatricians and family practitioners, respectively, were not educating their patients about lead poisoning.

Based on these findings, NJPLAC developed the 1997-1998 Physician Lead Education Initiative. The new initiative includes statewide hospital-based category I approved continuing medical education grand rounds slide shows about

the new law and

its implementing regulations presented by NJPLAC members; production and distribution of compliance kits—forms and letters, treatment guidelines, and parent education resources for physicians; a series of articles in the state's seven maternal and child health consortia' newsletters; audiotapes of the grand rounds presentations distributed by the consortia; Medicaid managed care presentations and compliance

kit distribution; the development and distribution of new guidelines; professional meeting presentations; and targeted professional publications. Future outreach through office-based nurses and physician opinion leaders is planned.

THE NEW LAW

Regulations implementing PL 1995 c. 328 were adopted on December 1, 1997. They require physicians to assess risk, screen, report, and perform followup on all children under six years of age to whom they provide health care services.¹⁶

Physicians are required to assess lead poisoning risk annually. The regulations require that physicians specifically inquire about prior testing; the condition of the home; and parental/guardian occupation or hobbies. If a risk assessment has not been performed in the past 12 months, one must be conducted, and written notes from that assessment placed in the child's medical record. The regulations also stipulate that at the time of the risk assessment, the parent/guardian must be educated about lead poisoning prevention. A "yes" answer to any of the three risk assessment questions indicates high-risk status. A "no" answer to all of the questions indicates low-risk status.

Screening is required of all children between 9 and 18 months and between 18 and 27 months regardless of risk

assessment results. Children at greater risk should be screened every 6 months, starting at 6 months of age through 24 months of age, and whenever new sources of exposure are suspected. Children who have not been previously screened should be screened between the ages of 27 and 72 months. While venous blood samples are preferred, capillary (finger-stick) samples also are acceptable.

Physicians are exempt from screening children if the parent/

Karen Goldman, PhD, comments on New Jersey's lead law.



guardian objects and signs a waiver; the provider will not be providing followup care to the child (such as when a child is referred by the primary care physician to a specialist for a consultation); or is acting in an emergency situation. (In the second case, a written referral to a primary care provider for screening is required.) Signed waivers are to be kept with the medical record.

APPROPRIATE MEDICAL
THERAPY IS CRITICAL
ALTHOUGH MEDICAL
TREATMENT REGULATIONS
DO NOT EXIST.

elevated blood lead test result on a venous blood sample.

The second important followup step is consultation with local health departments. State law requires local health departments to conduct home investigations to identify lead hazards. Once an elevated blood lead level is reported by the laboratory to

DHSS, the state contacts the local health department. The local health department nurse and a lead inspector make an appointment to visit the home to help identify the source(s) of lead. In addition, nurses make home visits to assess, educate, and provide case management to families. As necessary, public health alerts about specific sources of lead exposure and/or lead risks are issued. These alerts are in addition to the development and distribution of lead education materials and information sheets about local health and social services.

Education is a key component of followup. The new regulations state that risk reduction education and nutritional counseling are required for each child with a blood lead level equal to or greater than 10 µg/dL of whole blood.

In addition to being taught how to control lead exposure in the home, parents must be counseled about the importance of serving their children foods high in iron and calcium and urged to cut back on fatty or fried foods that stimulate lead absorption.

Appropriate medical therapy also is critical. Medical treatment regulations do not exist, nor is there agreement among experts about what treatment strategies are most appropriate at specific elevated blood lead levels.

CHILDREN WITH MEDICAID

Federal regulations concerning children with Medicaid insurance are more stringent than the new state law, and supersede DHSS regulations. The Health Care Financing Administration considers all Medicaid children between 6 months and 6 years of age to be at risk for lead toxicity. Blood lead screening is required at 6 to 12 months of age,

The new law requires physicians to use New Jersey licensed laboratories to perform lead screening tests. The law also requires laboratories to report all blood lead test results to DHSS.

Reporting of all lead test results to a parent or caregiver is required of the physician. If the blood lead level is less than 20 µg/dL, an oral report to the parent or caregiver is the only requirement. In cases of a confirmed blood lead equal to or greater than 20 µg/dL, a written report, "in plain language" is required.

Followup includes appropriate diagnostics, local health department consultations, parent education, and appropriate medical therapy. In terms of diagnostics, "the physician, registered professional nurse, as appropriate, or health care facility shall obtain or make reasonable efforts to obtain, a venous confirmatory blood lead test whenever a capillary blood lead screening sample produces an elevated blood lead result." Elevated blood lead is defined in the new regulations as a blood lead test result equal to or greater than 20 µg/dL of whole blood. When a child has a confirmed elevated blood lead level test result, lead screenings must be performed on all siblings or other members of the same household who are between six months and six years of age, unless those children have been screened within the last three months. A confirmed elevated blood lead is an

at age 2, and yearly until age 6. More frequent testing is recommended if any responses to the risk assessment are positive.

FINANCIAL COVERAGE

PL 1995 c. 316 requires all health care insurance providers to cover the cost of lead screening of children. No deductible is required, and all insurance groups with 50 or more members are covered. All children with Medicaid insurance are automatically covered. The only group for whom there is no financial support for the cost of lead screening is children whose parents are uninsured or insured by companies with fewer than 50 employees. To help address this problem, children who do not have health insurance or whose insurance does not cover lead testing can be referred to local health departments for free or reduced-cost screening.

CONCLUSION

New Jersey is an industrial state with a significant proportion of aging housing stock, an extensive network of leaded gasoline contaminated traffic corridors, widespread leaded pesticide use, and a preponderance of lead paint and pipes contaminating old homes. These factors are compounded by the continuous influx of immigrant groups who use leaded home remedies, cosmetics, and/or pottery. To deal with the health issues created by these factors, universal childhood lead screening is now a statewide requirement.

REFERENCES

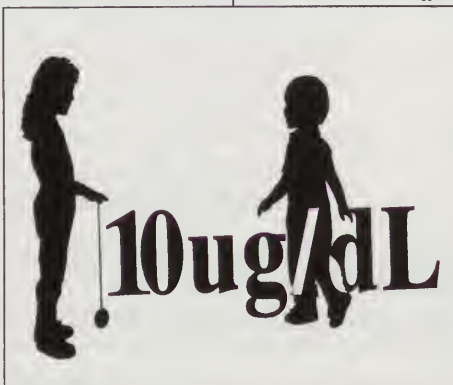
1. CDC: Preventing lead poisoning in young children: A statement by CDC. Atlanta, GA, CDC, October 1991.
2. Pocock SJ, Smith M, Baghurst PA: Environmental lead and children's intelligence: A systematic review of the epidemiological evidence. *BMJ* 309:1189-1197, 1994.
3. Bellinger D, Leviton A, Waternaux C: Low-level lead exposure, social class, and infant development. *Neurotoxicol Teratol* 10:497-503, 1989.
4. Bellinger D, Sloman J, Leviton A, et al.: Low-level lead

exposure children's cognitive function in the preschool years. *Pediatrics* 87:219-227, 1991.

5. Needleman HL, Gatsonis CA: Low-level lead exposure and the IQ of children. *JAMA* 263:673-678, 1990.
6. Needleman HL, Schell A, Bellinger D, et al.: The long-term effects of exposure to low doses of lead in childhood: An 11-year followup report. *N Engl J Med* 322:83-88, 1989.
7. Mahaffey KR: Exposure to lead in childhood. *N Engl J Med* 327:1308-1309, 1992.
8. Sciarillo WG, Alexander G, Farrell KP: Lead exposure and child behavior. *AJPH* 82:1356-1360, 1991.
9. White GL, Barnes SE: Lead poisoning: A public health emergency. *Clin Rev* 54-83, 1992.
10. Brody DJ, Pirkle JL, Kramer RA, et al.: Blood lead levels in the U.S. population: Phase I of NHANES III, 1988-1991. *JAMA* 272:277-283, 1994.
11. Pirkle JL, Brody DK, Gunter EW, et al.: The decline in blood lead levels in the United States. *JAMA* 272:284-291, 1994.
12. CDC: Update: Blood lead levels—U.S., 1991-1994. *MMWR* 46:141-146, 1997.
13. U.S. Bureau of Census: U.S. Census, 1990. Washington, DC, May 1992.
14. CDC: Screening young children for lead poisoning: Guidance for state and local public health officials. Atlanta, GA, CDC, 1997.
15. Goldman KD, Demissie K, DiStefano D, et al.: Childhood lead screening knowledge and practice: Results of a survey. *Am J Prev Med*, in press.
16. P.L. 1995, Chapter 328, approved January 5, 1996. New Jersey Senate and Assembly (NJSA) 26:2-137.2.

Dr. Goldman is affiliated with the Department of Urban Studies and

Community Health, Rutgers University. Ms. Ostrow is associated with the Graduate Program in Public Health. Dr. Ty is affiliated with UMDNJ-New Jersey Medical School, Department of Pediatrics. Dr. Rhoads is affiliated with UMDNJ-Robert Wood Johnson Medical School, Department of Environmental and Community Medicine.



Grand Rounds and Medical Seminars

September, 1998 through May, 1999

Grand Rounds 8:30 a.m.-9:30 a.m.

Visiting Professorships 8:30 a.m.-12:00 noon

Medical Seminars 8:30 a.m.-3:30 p.m.

Lecture Hall A/B

2nd Floor College Building, Allegheny University Hospitals, Hahnemann
15th & Vine Streets (16th Street Entrance), Philadelphia

For more information, contact the Office of Continuing Medical Education at 215-762-8263.

SEPTEMBER 1998

SEPTEMBER 9th

New Perspectives in Iron Overload Disorders

John L. Gollan, M.D.

Professor of Medicine
Harvard Medical School
Chief of Gastroenterology
Director, Partners Liver Center
Brigham and Women's Hospital
Boston, MA

SEPTEMBER 16th

Frontiers in the Treatment of HIV and HIV Complications

Bruce D. Walker, M.D.

Professor of Medicine
Harvard Medical School
Director, Partners AIDS Research Center
Massachusetts General Hospital
Boston, MA

Roger J. Pomerantz, M.D.

Professor of Medicine, Biochemistry and Molecular Pharmacology
Thomas Jefferson School of Medicine
Chief, Division of Infectious Diseases
Director, Center for Human Virology
Thomas Jefferson Medical Center
Philadelphia, PA

SEPTEMBER 23rd

Urinary Tract Infections: A Case Based Approach

Elias Abrutyn, M.D.

Professor of Medicine and Public Health
Interim Chair, Department of Medicine
Allegheny University Hospitals

SEPTEMBER 30th

No Grand Rounds—Yom Kippur

OCTOBER 1998

OCTOBER 7th

Malabsorption

Robert M. Craig, M.D.

Professor of Medicine
Northwestern University School of Medicine
Chief, Division of Gastroenterology
Northwestern Medical Center
Chicago, IL

OCTOBER 14th

Community Acquired Pneumonia: Update on Diagnosis and Therapy

Michael S. Niederman, M.D.

Professor of Medicine
SUNY, Stony Brook
Chief, Division of Pulmonary and Critical Care Medicine
Winthrop University Hospital
Mineola, NY

OCTOBER 21st

Interpretation of Randomized Trials and Their Application in Clinical Practice

Robert L. Frye, M.D.

Professor and Chair
Department of Internal Medicine
Cardiovascular Consultant
The Mayo Clinic
Rochester, MN

OCTOBER 28th

Giant Cell Arteritis

Bruce Hoffman, M.D.

Professor of Medicine
Allegheny University of the Health Sciences
Chief, Division of Rheumatology/Immunology
Allegheny University Hospitals, MCP

NOVEMBER 1998

NOVEMBER 4th

Surviving Heart Failure

William Parmley, M.D.

Professor of Medicine
University of California at San Francisco
Chief, Division of Cardiology
Moffet/Long Hospital
San Francisco, CA

NOVEMBER 11th

Diagnosis and Management of Lung Cancer

Joseph Treat, M.D.

Professor of Medicine
Director, Thoracic Oncology
Allegheny University Hospitals

NOVEMBER 18th

Syndrome X: Ten Years of Experience

Gerald M. Reaven, M.D.

Professor of Medicine
Stanford University School of Medicine
Stanford, CA

NOVEMBER 25th

No Grand Rounds—Thanksgiving Holiday

DECEMBER 1998

DECEMBER 2nd

JNC-VI

Ray W. Gifford, M.D.

Professor of Internal Medicine
Ohio State University College of Medicine
Consultant, Department of Nephrology and Hypertension
Cleveland Clinic Foundation
Cleveland, OH

Kenneth A. Jamerson, M.D.

Associate Professor of Internal Medicine
Department of Internal Medicine
Division of Hypertension
University of Michigan Medical Center
Ann Arbor, MI

Marvin Moser, M.D.

Clinical Professor of Medicine
Yale University School of Medicine
Senior Medical Consultant
National High Blood Pressure Education Program
National Heart, Lung and Blood Institute
Bethesda, MD

DECEMBER 9th

Cardiac Auscultation

Bernard L. Segal, M.D.

Professor of Medicine
Allegheny University of the Health Sciences
Philadelphia, PA

DECEMBER 16th

Type II Diabetes Mellitus

Jay Skyler, M.D.

Professor of Medicine
University of Miami School of Medicine
Miami, FL

DECEMBER 23rd

No Grand Rounds—Christmas Holiday

DECEMBER 30th

No Grand Rounds—New Year's Holiday

Wednesday Medical Seminar Series—8:30 a.m. to 3:30 p.m.

SEPTEMBER 16, 1998

Frontiers in the Treatment of HIV

Course Director: Maria J. Gold, M.D.

Seminar Director: Allan B. Schwartz, M.D.

OCTOBER 14, 1998

Diagnosis and Treatment of Pulmonary Infection

Course Director: Edward S. Schulman, M.D.

Seminar Director: Allan B. Schwartz, M.D.

NOVEMBER 11, 1998

Advances in the Management of Lung Cancer

Course Director: Joseph Treat, M.D.

Seminar Director: Allan B. Schwartz, M.D.

DECEMBER 2, 1998

Update on the Management of Hypertension:

JNC-VI

Course Director: Bonita Falkner, M.D.

Seminar Director: Allan B. Schwartz, M.D.

DECEMBER 9, 1998

Cardiac Auscultation for Office Practice

Course Director: Bernard L. Segal, M.D.

Seminar Director: Allan B. Schwartz, M.D.

Seminar Director: Allan B. Schwartz, M.D., Professor of Medicine, Chief of Service, Director of Continuing Medical Education for the Department of Medicine

Full Disclosure Statement: All faculty participating in continuing medical education programs sponsored by Allegheny University of the Health Sciences are expected to disclose to the audience any real or apparent conflict(s) of interest related to the content of their presentation.

Statement of Accreditation: Allegheny University of the Health Sciences is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education programs for physicians. Allegheny University of the Health Sciences designates 1.0 credit hour of category I of the Physician's Recognition Award of the American Medical Association for each hour of attendance at these continuing medical education activities. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

This program is eligible for 1.0 credit hour for each hour of attendance in category 2A of the American Osteopathic Association.

JULIE GOLDMAN

The New Jersey Medicine Interview

ll Berlin, PhD

JULIE GOLDMAN WAS DIAGNOSED WITH BREAST CANCER IN SEPTEMBER 1994. ONE YEAR AFTER COMPLETING SURGERY, RADIATION, AND CHEMOTHERAPY TREATMENTS, METASTASES WERE DISCOVERED IN HER LIVER AND RIGHT LUNG. JULIE RESIDES AT THE STANLEY TIPPETT HOME, AN HOSPICE HOUSE, AND RECEIVES PALLIATIVE CHEMOTHERAPY FOR METASTATIC BREAST CANCER. JULIE GREW UP IN SOMERSET. AS A JACOB AVITS SCHOLAR, SHE IS A DOCTORAL CANDIDATE IN THE DEPARTMENT OF ANTHROPOLOGY AT HARVARD UNIVERSITY.

Q. What have you been saying to physicians?

A. I start out talking about the issue of translation, which is something about which anthropologists talk. Translation involves finding ways to overcome the barriers that separate us because of experience or background. Medical professionals go through a very precise training that makes them think about the body in a certain way, but also gives them a whole body of experience. They have to work in the hospital for 90 hours a week and do all this crazy stuff that no patient who is lying in a hospital bed has to do.

On the other side, the doctor doesn't really know the physical

experience of being a patient. The doctor hasn't taken chemotherapy and doesn't know what it's like for each cell in your body to be under siege. We need to dig down into our experience, our imagination, to all of the resources that we have as people and try to bridge these gaps of communication. I think, quite often, it's very easy for doctors to hide in their world and for patients to feel resentment and hide in their world. It's been my experience that there are significant and rather simple ways of understanding.

Q. Is that because of the language a physician uses?

A. When I was rediagnosed as terminal and incurable, my oncologist said that this is a chronic

disease and not to look at it as a death sentence. She also asked me what my goals were and helped use that information to create my treatment plan. At first, my goals were to get in remission, which is the real heavy stuff. Then, my goal was to be able to live my life. So we went about finding chemotherapies that would enable me to still teach and do the other activities that make my life worth living.

There also was a time after my rediagnosis with terminal cancer that I was beginning to feel some symptoms that were not significant, but she never made me feel that what I was talking about was insignificant. She showed me how, despite these symptoms, I still would be able to accomplish my goals.

Q. I think some physicians also feel that they need to protect themselves from their own hurt, disappointment, or guilt.

A. And from feeling incompetent because the physician hasn't been able to cure the person. I have a friend who was diagnosed and I didn't know what to say to her. We use these regular words that we use all the time. I wish we could speak in

In the Spotlight

italics or somehow not use the fluorescent lighting vocabulary of the hospital and use a softer tone. But when you're pressured and you're busy and you're caught up in your work, I think it tends to come out in much more mechanical ways.

One of the other themes that I talk about is that this whole vocabulary is a bit twisted. When it comes to illness, weakness isn't weakness. It's actually where you're developing strength. Getting through chemotherapy involves tremendous suffering, and we have to realize that what seems like weakness isn't weakness at all. It's the way that they're developing their strength and the doctor can really have an input there. For example, when I went in for one of my post-treatment check-ups, my radiation oncologist said, "How are you?" I started talking about this that, or the other thing on my body. He said, "No, how are you? We have observed that about six months after treatment patients go through a little depression." Many doctors never tell their patients about this. Maybe doctors don't tell them because of the placebo effect. But instead, the patient feels isolated, because feelings are not being acknowledged. So my doctor took the time, not only to ask the question, but to be willing to hear the answer.

Q. How important is the environment itself in which you are living?

A. I wanted to look at my apartment and my mother's home



Julie Goldman

as living spaces. When I got very sick, and I began to feel like I would need a lot of assistance, I felt it was necessary to find a different living space like a hospice. The irony of it all is that I've gotten better than anyone would have imagined, and in the hospice I keep seeing people die. I've gained weight and strength, and yet at the same time, I still need my morning and afternoon shots. I'm still on morphine and I still need care.

Q. What about the hospital environment?

A. It's a mixed bag. Being in a hospital became unpleasant. There was a time when it was a safe space and then it became a time when I really just wanted to get off the tubes and out of there. I'm lucky I was able to do so, because in a hospital it's more likely that you'll get treated more as a procedure than as a person, especially because you're subject to doctors other than your own. Some doctors see lots of patients all the time, and it's barely

even a consideration to develop a relationship with someone. They should be able to find a personal connection even if it's just saying, "I hope you feel better!" You think something small can really make a difference in that scrutinized environment, where you're constantly being poked and prodded.

Q. In a hospice, you are poked and prodded as well but the environment is very different.

A. Yes, and it's also different because in a hospital there are rounds where you actually get physically examined. I don't like that in a hospice. I get my shots and there's no one coming in to listen to my chest and pound on it or doing a full physical exam. I only get that through my doctor. The hospice folks say that they're like a private home. So there really is a whole other category where there's a degree of privacy that you can't get in hospice that you don't have in a hospital.

Q. I hear your voice getting tired.

A. Yes, I probably am getting a little tired. I do feel this is very important, and what I want to demonstrate is that between doctor and patient there's not too much distance. We're not that far apart. We can really find ways to communicate that are easy and really make a difference.

CME Course



15TH ANNUAL CLINICAL UPDATE IN PULMONARY MEDICINE

Saturday, December 5, 1998 • Atlantic City Convention Center • Atlantic City, NJ

Designed for Pulmonologists, Internists, Family Practitioners, General Practitioners and Allied Health Professionals

6.75 Credit Hours Category 1 AMA and AAFP

6.75 Credit Hours Category 2-A AOA

PROGRAM

The Role of Leukotriene Modifiers in the Treatment of Asthma James E. Fish, MD
Upper Respiratory Tract Infections: Treatment and Complications Dennis G. Maki, MD
New Developments in Obstructive Sleep Apnea Allan I. Pack, MD, PhD
Diagnosis and Treatment of Fungal Infections of the Lung Dennis G. Maki, MD
New Treatment Strategies in Adult Respiratory Distress Syndrome ... James E. Gadek, MD
Update on the Management of COPD Michael A. Grippi, MD
Diagnosis and Management of Interstitial Lung Disease James E. Gadek, MD
New Developments in the Early Detection of Lung Cancer David M.F. Murphy, MD

For further information, please contact:

CME Department

Center for Bio-Medical Communication, Inc.

433 Hackensack Avenue, 9th Floor, Hackensack, New Jersey 07601

201/342-5300 Fax: 201/342-7555 E-mail: cmelinfo@cbcbiomed.com

PAIN MANAGEMENT STRATEGIES

FOR THE PRIMARY CARE SPECIALIST

Friday, November 20, 1998

The course is directed to primary care specialists who have an interest in the overall evaluation of the patient with pain and in the various modalities of pain management. This includes general practitioners, family practice physicians, internists, psychiatrists, neurologists, and all health professionals whose practice involves the care of patients suffering from acute or chronic pain.

The program will present a primer of the latest developments in the pathophysiology, diagnoses and treatments of pain. Each talk will focus on specific topics directly relevant to the practical problems that a primary care specialist may encounter when confronted with a pain patient. It will summarize the main solutions available to provide the best "state of the art" care to such a patient. Pain specialists from eight different specialty backgrounds will contribute to this meeting and will bring their unique experiences and points of view. This diversity will make this program a truly comprehensive review course. In addition, two sessions will be spent on clinical case presentations which will allow interaction and discussion of "real pain problems" with the participants.

The goal of the course is to familiarize the participants with the latest diagnostic and therapeutic tools available to the primary care specialist in order to deal with the large variety of pain problems. It will also help to define the relative role of the primary care specialist and of other specialists in the overall management of pain patients and their interaction. Finally, the participants will be given enough time to ask questions of the faculty.

At the conclusion of the course, the participants should be aware of all current basic advances in the field of pain medicine.

Course Director: Michel Y. Dubois, M.D. **Course Co-Director:** Gerard Varlotta, D.O.

Accreditation: 8 hours, Category 1 AMA **Tuition:** \$156 **Reduced Tuition:** \$113

For further information contact the NYU Post-Graduate Medical School at: (212) 263-5295

Visit our website at <http://www.scanet.com/nyupgms>

NJM '98



Post-Graduate Medical School

CALENDAR

E V E N T	D A T E	L O C A T I O N
-----------	---------	-----------------

S e p t e m b e r		
-------------------	--	--

Oral Cancer Symposium	September 23, 1998	Woodbridge Hilton, Woodbridge, AMNJ, 609.275.1911
Domestic Violence Issues	September 23, 1998	Union Hospital, Union, AMNJ, 609.275.1911
Review of New Antibiotics	September 23, 1998	St. Mary's Hospital, Passaic, AMNJ, 609.275.1911
Excess Mortality in African Americans and Other Minorities	September 23, 1998	Dept. of Health and Senior Services, Trenton, AMNJ, 609.275.1911
Gynecology CME Course: A Clinical Update	September 25, 1998	Crowne Plaza, New York City, 201.385.8080, ext. 26
The Future of Medical Rehabilitation	September 25, 1998	Kessler Conference Center, West Orange, AMNJ, 609.275.1911
Emergency Care of Heart Attacks	September 30, 1998	St. Mary's Hospital, Passaic, AMNJ, 609.275.1911

O c t o b e r		
---------------	--	--

Treatment of Bulimia Nervosa	October 1, 1998	Carrier Foundation, Belle Mead, AMNJ, 609-275-1911
MRI Symposium	October 6, 1998	Somerset Marriott Hotel, Somerset, AMNJ, 609.275.1911
Sports Medicine '98	October 7, 1998	MSNJ Headquarters, Lawrenceville, 609.896.1766
Blood Glucose Control and Diabetes	October 7, 1998	St. Mary's Hospital, Passaic, AMNJ, 609.275.1911
Cancer Survivorship	October 8, 1998	Caesar's Hotel, Atlantic City, 212.366.6565
Physical Medicine and Rehabilitation Meeting	October 10, 1998	East Brunswick Hilton, East Brunswick, AMNJ, 609.275.1911
Managed Healthcare Forum	October 11, 1998	Marriott Hotel, Washington, DC, 1.800.642.2515
Viral Infections of Skin	October 13, 1998	Schering Corporation, Kenilworth, AMNJ, 609.275.1911
Diseases of the Pituitary	October 14, 1998	St. Mary's Hospital, Passaic, AMNJ, 609.275.1911
Care of the Elderly in a Long-Term Setting	October 14, 1998	The Forrester Center at Princeton, Princeton, AMNJ, 609.275.1911
Management of HIV and Other Blood-Borne Pathogens	October 14, 1998	Union Hospital, Union, AMNJ, 609.275.1911
Lyme Disease and Chronic Fatigue Syndrome	October 17, 1998	College of Physicians and Surgeons, New York, 212.781.5990
Colitis	October 21, 1998	St. Mary's Hospital, Passaic, AMNJ, 609.275.1911
Endocrinology Lecture	October 21, 1998	VA Medical Center, East Orange, AMNJ, 609.275.1911
Alzheimer's Disease	October 28, 1998	St. Mary's Hospital, Passaic, AMNJ, 609.275.1911
Diagnosis and Management of HIV	October 29, 1998	VA New Jersey Health Care System, Lyons, AMNJ, 609.275.1911

ATTENTION!

That's what you'll get at the College of Saint Elizabeth.

GRADUATE DEGREE PROGRAMS OPEN HOUSE

Monday, October 5, 6pm-8:30pm, *St. Joseph Hall*
(973) 290-4100 / graduate@liza.st-elizabeth.edu

ADULT UNDERGRADUATE DEGREE PROGRAMS OPEN HOUSE

Tuesday, November 10, 9am-6:30pm, *Henderson Hall*
Thursday, November 12, 3pm-8pm, *Henderson Hall*
(973) 290-4600 / audp@liza.st-elizabeth.edu

Weekend & Evening Undergraduate Degrees

B.S. in Business Administration
B.A. in Communication
B.S. in Computer Science
B.A. in English
B.S. in Foods & Nutrition
B.A. in International Studies
B.A. in Psychology

Weekend & Evening Graduate Degrees

We offer seven degree programs including:

M.S. in Counseling Psychology
M.S. in Management
M.S. in Health Care Management
M.S. in Nutrition

B.S. in Nursing For R.N.'s

Continuing Studies Day Program (BA/BS)

27 majors from Art to Education to Sociology

Getting the personal attention you deserve can make getting your degree easier to handle. That's why we go out of our way to understand adult students, your concerns, and your needs. It starts at our Open House, where we'll evaluate your records, and answer all your questions one-on-one. You'll find the same attitude once you're enrolled, whether you're seeking a bachelor's degree, master's degree or a non-degree certificate program. Find out more about our refreshing approach by joining us at our Open House. Enjoy refreshments, pick up a great T-shirt, and see what a difference all that attention can make.

COLLEGE OF
SAINT ELIZABETH

Where our most important subject is you.

2 Convent Road, Morristown, NJ
www.st-elizabeth.edu

UPDATE '98:

MANAGEMENT OF DIFFICULT TO HEAL WOUNDS

A SYMPOSIUM FOR PHYSICIANS

"UPDATE '98: Management of Difficult to Heal Wounds"

is a compact but comprehensive half-day program sponsored by the Wound Care Centers® of Northern New Jersey. This program is designed for the busy physician interested in enhancing their clinical expertise in the management of difficult to heal wounds.

DATE: FRIDAY, NOVEMBER 6, 1998

PLACE:



The Manor

111 PROSPECT AVENUE, WEST ORANGE, NJ 07052

ACCREDITATION FOR C.M.E. CREDITS

Englewood Hospital and Medical Center is accredited by the Medical Society of New Jersey to sponsor continuing education for physicians. Attendance at this program has been designated as providing 4 hours of Category 1 credits toward the AMA Physicians Recognition Award. Application has been made to the New Jersey Podiatric Society for category 1 credits.

PROGRAM

- 7:30 A.M.** Registration/Exhibits/Continental Breakfast
- 8:00 A.M.** Welcome by Moderator
Mark Doyne, MD
Vice President of Medical Affairs
Curative Health Services - Hauppauge, NY
- 8:15 A.M.** "Etiology of Diabetic Foot Wounds:
Obstacles to Healing"
Marvin E. Levin, MD, FACP
Professor of Clinical Medicine and Associate
Director of the Diabetes, Endocrinology and
Metabolism Clinic at Washington University
School of Medicine - St. Louis, MI
- 9:00 A.M.** "Assessing the Circulatory Status
of the Lower Extremity"
Herbert Dardik, MD, FACS
Director of Vascular Institute and
Chief, Department of Vascular Surgery,
Englewood Hospital and Medical Center,
Englewood, NJ
- 9:45 A.M.** Break
- 10:00 A.M.** "Approaches to the Management of
Chronic Wound Infections"
Catherine J. Hardalo, MD
Associate Clinical Project Director
at Schering Plough Research Institute,
Kenilworth, NJ
- 10:45 A.M.** "Hyperbaric Oxygen and its Adjunctive
Role in Wound Healing"
Eric P. Kindwall, MD
Kindwall Consulting, Brookfield, WI
- 11:30 A.M.** "Wounds of Uncommon Etiologies -
Making the Appropriate Diagnosis"
Vincent Falanga, MD, FACP
Professor and Chairman, Department of
Dermatology and Skin Surgery, Roger
Williams Medical Center, Providence, RI
- 12:15 P.M.** Panel Discussion and Evaluation
- 12:45 P.M.** Buffet Luncheon

REGISTRATION



PLEASE REGISTER ME FOR
THE CONFERENCE ONLY



PLEASE REGISTER ME FOR
THE CONFERENCE AND LUNCH

Name _____

Specialty _____

Hospital Affiliation _____

Address _____

City _____

State _____ Zip _____

Phone (_____) _____

- ▶ NO FEE—BUFFET LUNCH PROVIDED
- ▶ REGISTER EARLY—SPACE IS LIMITED
- ▶ R.S.V.P. BY OCTOBER 30, 1998

MAIL TO: WOUND CARE CENTER®
95 MT. KEMBLE AVE., MORRISTOWN, NJ 07960
OR FAX TO: 973-290-7642

FOR ADDITIONAL INFORMATION, CALL

1-800-447-3337

THE MEDICAL SOCIETY OF NEW JERSEY CLASSIFIED ADVERTISEMENT INSERTION REQUEST

RATES

(Placement in New Jersey *MEDICINE* OR on WEB Site)

New Jersey *MEDICINE*

<http://www.msnj.org>
WEB Site

Month—Non-Members		
Minimum 45 words	\$ 45.00	
Each word		
Per 45 words	\$ 1.00	
Month—Members		
Minimum 45 words	\$ 30.00	
Each word		
Per 45 words	\$ 1.00	
Month—		
Minimum 45 words		\$ 45.00
Each word		
Per 45 words		\$ 1.00

(Placement in New Jersey *MEDICINE* AND on WEB Site)

New Jersey *MEDICINE*

<http://www.msnj.org>
WEB Site

Month—Non-Members		
Minimum 45 words	\$ 45.00	\$ 36.00
Each word		
Per 45 words	\$ 1.00	\$.80
Month—Members		
Minimum 45 words	\$ 30.00	\$ 36.00
Each word		
Per 45 words	\$ 1.00	\$.80

PREPARE YOUR COPY ON A SEPARATE PAGE AND ATTACH TO THIS ORDER FORM

INSERTION AUTHORIZATION

are _____ MSNJ Member? Yes _____ No _____
 Company _____ Telephone Number _____
 Address _____ Fax Number _____
 City _____ State _____ ZIP _____
 New Jersey *MEDICINE* Issues _____
 Number of 30 Day Insertions _____

New Jersey *MEDICINE*

Non-Member
 Minimum 45 Words \$ 45.00
 Each Add'l Word @\$1.00 \$ _____
 Per Issue \$ _____
 Number of Issues _____
 AMOUNT DUE \$ _____

New Jersey *MEDICINE*

Member
 Minimum 45 Words \$ 30.00
 + Each Add'l Word @\$1.00 \$ _____
 Per Issue \$ _____
 X Number of Issues _____
 AMOUNT DUE \$ _____

MSNJ WEB SITE

Non-Member or Member
 Minimum 45 Words \$ 45.00
 Each Add'l Word @\$1.00 \$ _____
 Per Month \$ _____
 Number of Months _____
 AMOUNT DUE \$ _____

MSNJ WEB SITE WITH NEW JERSEY *Medicine* Placement

Non-Member or Member
 Minimum 45 Words \$ 36.00
 + Each Add'l Word @\$.80 \$ _____
 Per Month \$ _____
 X Number of Months _____
 AMOUNT DUE \$ _____

TOTAL DUE \$ _____ ALL CLASSIFIED ADS MUST BE PRE-PAID

Please make check payable to "Medical Society of New Jersey"

Mail to: Classified Ad Department
 370 Morris Avenue
 Trenton, NJ 08611

Tel: 609-393-7196
 Fax: 609-393-3759

CLASSIFIED ADS

100 OPENINGS PHYSICIANS (MULTIPLE SPECIALTY LISTINGS)

FAMILY PRACTICE

Excellent opportunity for a physician to join an established Family Practice in Morris Plains, Morris County, New Jersey. Salary commensurate with experience. Will introduce. Terms available. Please fax resume ATTN: FAP (516) 665-0555.

PODELL MEDICAL CENTER

The Podell Medical Center is looking for physicians who are well-trained in conventional and alternative medicine to join our integrative health and medical care center. Please ask for Judy Aiello. Richard N. Podell, MD, MPH, Clinical Professor, Department of Family Medicine, UMDNJ Robert Wood Johnson Medical School. Telephone: 904-464-3800. Fax: 908-464-3078.

110 OPENINGS PHYSICIANS (ALPHABETICAL BY SPECIALTY)

BC/BE ANESTHESIOLOGIST

Pain Management Only—New Jersey (Central/Northern—1/2 hr. from N.Y.C.). Outstanding private practice opportunity for motivated BC/BE Anesthesiologist. Pain Fellowship is a plus. F/T or P/T. Most established pain group in the state. No night calls or wknds. Excel. compensation. Avail. Immediately. Fax short CV & cover letter to 732-651-0375.

GASTROENTEROLOGIST

Thirty physician multi-specialty, multi-site group independently owned seeking GI to join as either shareholder or employed physician. Offices located in Ocean and Monmouth Counties. Call 732-295-5942 or mail cv to Administrator, PO Box 1028, Brick, NJ 08724.

INTERNAL MEDICINE

Internal Medicine. Family Practice. Mercer County/Princeton Area. Seeking BC/BE Internist/Family Practitioner to join busy medical practice in the Mercer County, Princeton Area. Competitive Salary, full Benefits Package. Recent Residency Graduates welcomed. Contact Dr. Joseph De Blasio. 609-586-6006.

BC/BE PEDIATRICIAN

Part time, Holmdel area, flexible schedule. Fax CV to 732-888-0012.

RADIOLOGIST

Private imaging center by the Jersey Shore is in need of two Board Certified Radiologists; one Full-time with experience & training in MRI & CT & one Part-time with experience in Mammo, Sonogram & Nuclear Medicine. Send resume to P.O. Box #140, New Jersey MEDICINE, 370 Morris Avenue, Trenton, NJ 08611.

EMERGENCY PHYSICIANS

Emergency Physician Associates, a Team Health affiliate, is seeking quality ED physicians for a variety of practice opportunities in NJ, PA, DE, MD, NC and NY.

We offer physicians competitive compensation, flexible schedules, malpractice insurance, a variety of practice settings, and supportive Medical Directors.

Interested candidates may call

1-800-848-EPA-1.

130 OPPORTUNITY WANTED

BC FAMILY PRACTITIONER

BC Family Practitioner—Seeks PT/FT employment. Call 973-994-1617.

200 PRACTICE FOR SALE

FAMILY PRACTICE— EAST BRUNSWICK

Solo Family Practice in East Brunswick. Happy practice: newborns, children, adults, old folks, women's health. No OB, no HMO's. Ideal opportunity to be a real doctor! Call 792-0170.

ORTHOPEDIC SURGEON— MONTCLAIR

Estate of a deceased Orthopedic Surgeon with office in Montclair, NJ desires to sell substantial medical practice. Call 201-489-5400, ask for Sheri.

300 OFFICE RENTALS AND LEASES

EDISON

Office Space—Edison Medi-Plex Building opposite J.F.K. Hosp. Fully equipped, turn-key. Rent day, full day, night. 732-494-6300.

MILLBURN

Medical Arts Building. Millburn Avenue. Fully equipped, turn key. Rent day, 1/2 day, night. Call 973-376-8670.

MORRIS COUNTY

Medical Office Space. 2,000 Sq. Ft. Fully equipped. Occupied 35 years. Ideal for partnership or small group. Lake Hepatcong. 973-663-5306.

PARSIPPANY-MORRIS PLAINS

Medical Arts Plaza, 2839 route 10 (opposite Powder Mill West), Parsippany-Morris Plains. 925 S.F. Large Waiting Room. Large Private Office. 2 Exam Rooms with sinks. Utility Closet. Manager's Office. Work Station with sink/vanity. Lavatory. New Carpets. New Central HVAC. Professional Atmosphere. Building recently purchased and extensively renovated. Impressive Demographics. Plus an additional 1,435 S.F. available soon. Call Owner—973-228-5879.

330 MEDICAL BUILDING FOR SALE

BAYSHORE-HOLMDEL

Bayshore/Holmdel Medical Building. 14,000 sq. ft. adjacent to Robert Wood Johnson/Bayshore Medical Center. Elevator, grade level access to two floors, leased, prestige brick building on great corner. \$1,200,000. Stafford Smith LLC, Commercial Realty Brokerage, (732) 517-0100.

RED BANK—MERIDIAN HEALTH

Red Bank/Meridian Health. 3,500 sq. ft. office condominium adjacent to medical center. Elevator, parking, very convenient location for two practices. \$349,000. Stafford Smith LLC, Commercial Realty Brokerage 732-517-0100.

460 PRACTICE MANAGEMENT SYSTEM

HEALTH MANAGEMENT SYSTEM

Announcing from SoftPro Systems: A new Health Management System/billing package for physicians and labs. Windows based, friendly, easy and fun to use. Send forms directly to insurance companies. Obtain medical records at the click of a button. Schedule appointments. Call immediate details: 609-936-9200.

500 MEDICAL EQUIPMENT FOR SALE

CBC MACHINE

Becton & Dickerson, Accutube, QBC Analyzer with QBC Centrifuge and Canon BJC Color Printer Included. Practically Brand New Top Condition, \$2450; OR Best Offer. Call 732-914-8877. Ask for Judy.

CBC MACHINE

Essentially new Danam Excell CBC machine for sale or lease. 732-528-8882.

MOBILE VASCULAR LAB

Life Sciences "modulab" mint condition. Modules: Arterial, Venous PVR, CWD, Doppler, Phonoangiogram, probes, 5 pairs stereo headphones, remote, foot pedal screen, Fujitsu color printer, current soft archiver, add'l modules available, complete wheeled cart, free company tech train. \$13,500 profitable. 609-384-9000.

520 NEW EQUIPMENT— LEASING/FINANCING

EQUIPMENT LEASING/FINANCING

HPSC specializes in financing healthcare practice equipment, working capital, leasehold improvements, supply contracts, start-ups, competitive fixed rates. Response within hour, by phone or fax. Over 72,000 dollars financed with incredible service! \$150,000 down payment only. All contracts funded, serviced house. We do not sell your contract to interested third parties. On practice acquisitions, buy-ins, we finance up to 100% of the price. Apply over the Internet; www.hpsc.com (secure site)! HPSC Financial Services 800-225-2488, Fax 800-526-0259.



SHORT HILLS

Ideal location for home & office. Gracious 5 bedroom, 3 1/2 bath Colonial in heart of Short Hills. Offered in impeccable condition. Wonderful details including arched doorways, bay windows and hardwood floors. Spacious 5 room attached office with two lavatories zoned for medical professional. Central air throughout. \$695,000. Prudential Brown-Flower Co., REALTORS (908) 766-5666.

YOUR OFFICE ... WHERE DOES IT HURT?

STAFF?
BILLING?
INSURANCE?
COLLECTIONS?
CPT/ICD CODES?
CODING UPDATES?

Your office will be evaluated and reorganized to operate with peak performance and efficiency, confidently and expertly. Whatever may be causing your daily office routines to be deficient ... will be diagnosed, examined and cured. Call for intensive care and expertise.

MARY ANN HAMBURGER
A S S O C I A T E S

THE SPECIALIST'S SPECIALIST
74 HUDSON AVE. MAPLEWOOD, N.J. 07040
973-763-7394

SHUTZ, POLLAND & ASSOCIATES, P.C.

THE LAW FIRM THAT SPECIALIZES IN HEALTH
CARE REPRESENTATION OF PHYSICIANS AND
OTHER HEALTH CARE PROFESSIONALS.
OUR AREAS OF EXPERTISE INCLUDE:

Managed Care Contracts with MSOs and HMOs.
Health Care Mergers/Joint Ventures/Acquisitions.
Development and implementation of Compliance
Audits and Plans.

Representations in Board of Medical Examiner
Cases.

Asset Protection/Estate Planning as protection
against malpractice suits.

Federal and State Anti-Kickbacks/Stark/Safe Harbor
representation.

Medicare/Medicaid/Third Part Audits

OUR EXPERT STAFF CONSISTS OF SPECIALIZED
TORNEYS AS WELL AS PHYSICIAN-ATTORNEYS.

SHUTZ, POLLAND & ASSOCIATES, P.C.
ATTORNEYS AT LAW

SOUTH ORANGE AVE., SO. ORANGE, NJ 07079
(973) 275-5009

75 THIRD AVENUE, NEW YORK, NY 10017
(212) 949-8484

<http://www.11fshutz-polland.com>

Malpractice insurance policies are strange animals. Beware of the ones with tails.

Most New Jersey malpractice insurance policies require you to purchase a reporting endorsement — known as a tail — to protect against claims that may occur during retirement. B.C. Szerlip offers a unique policy from an A+ rated company that does not include an annual tail premium. In fact, if you maintain coverage with us until retirement, you'll *never* have to purchase a tail, and you'll still be protected.

That's just one example of the creative ways that B.C. Szerlip has discovered to help doctors with their long-range financial planning.

At B.C. Szerlip, we take a big-picture view of your practice, offering you comprehensive insurance and financial planning services. You can benefit from our nearly two decades of experience providing malpractice insurance for medical offices both large and small. In addition, our financial planners can offer strategic guidance for the overall health of your business affairs, so you can stay focused on the health of your patients.

We'd like to give you a taste of our full-service approach by sending you *The Managed Care Survival Kit for Physicians*. To receive your complimentary copy of this useful guide, please call us at 800-684-0876.

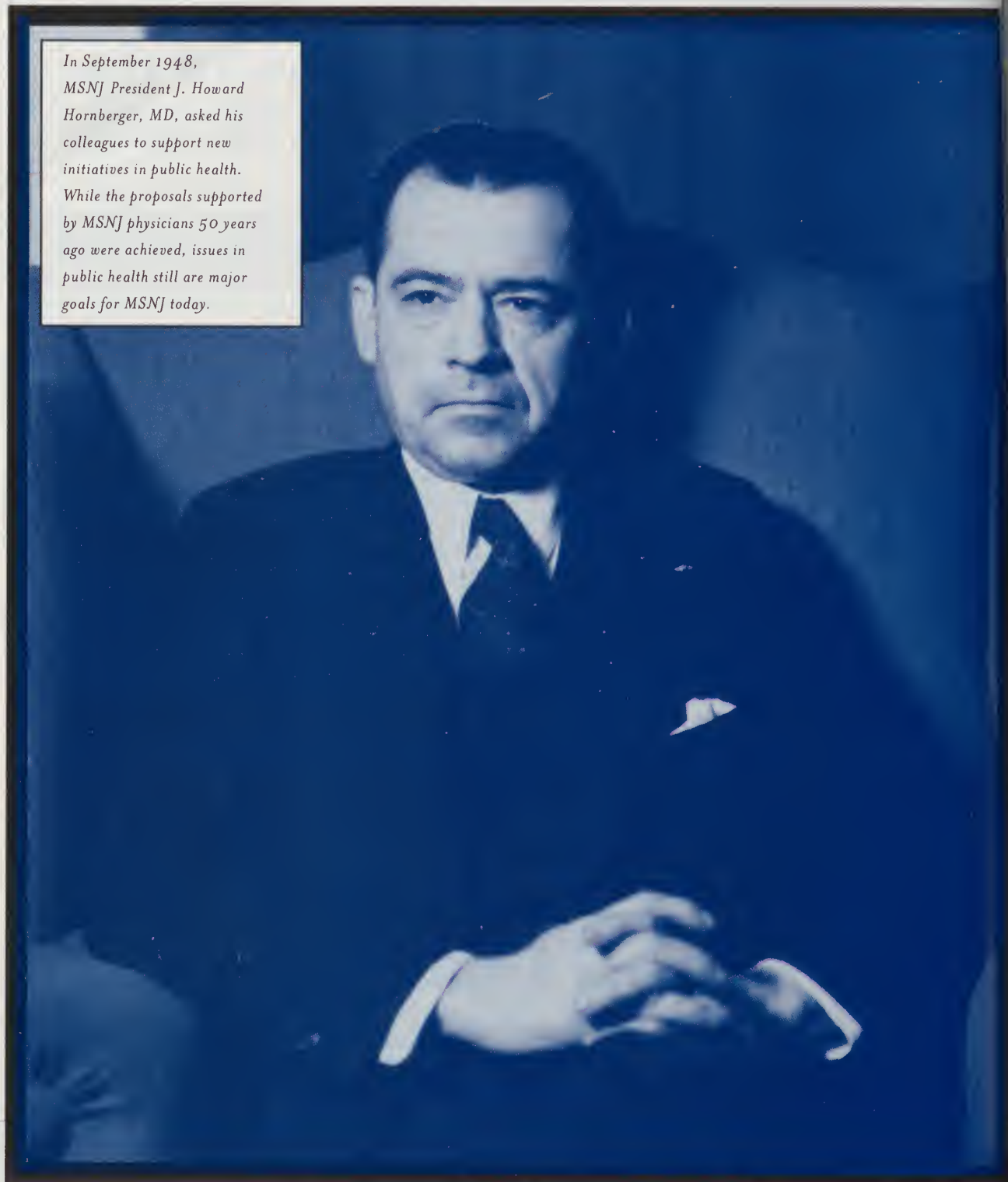
BCSZERLIP
INSURANCE AGENCY INC.

99 WOOD AVENUE SOUTH, PO BOX 217
ISELIN, NJ 08830-0217
800-684-0876 • 732-205-9800
FAX: 732-205-9496
E-MAIL: bcszerlip@aol.com

*Professional Insurance Services
for Health Care Providers*

Photo Finish

In September 1948, MSNJ President J. Howard Hornberger, MD, asked his colleagues to support new initiatives in public health. While the proposals supported by MSNJ physicians 50 years ago were achieved, issues in public health still are major goals for MSNJ today.

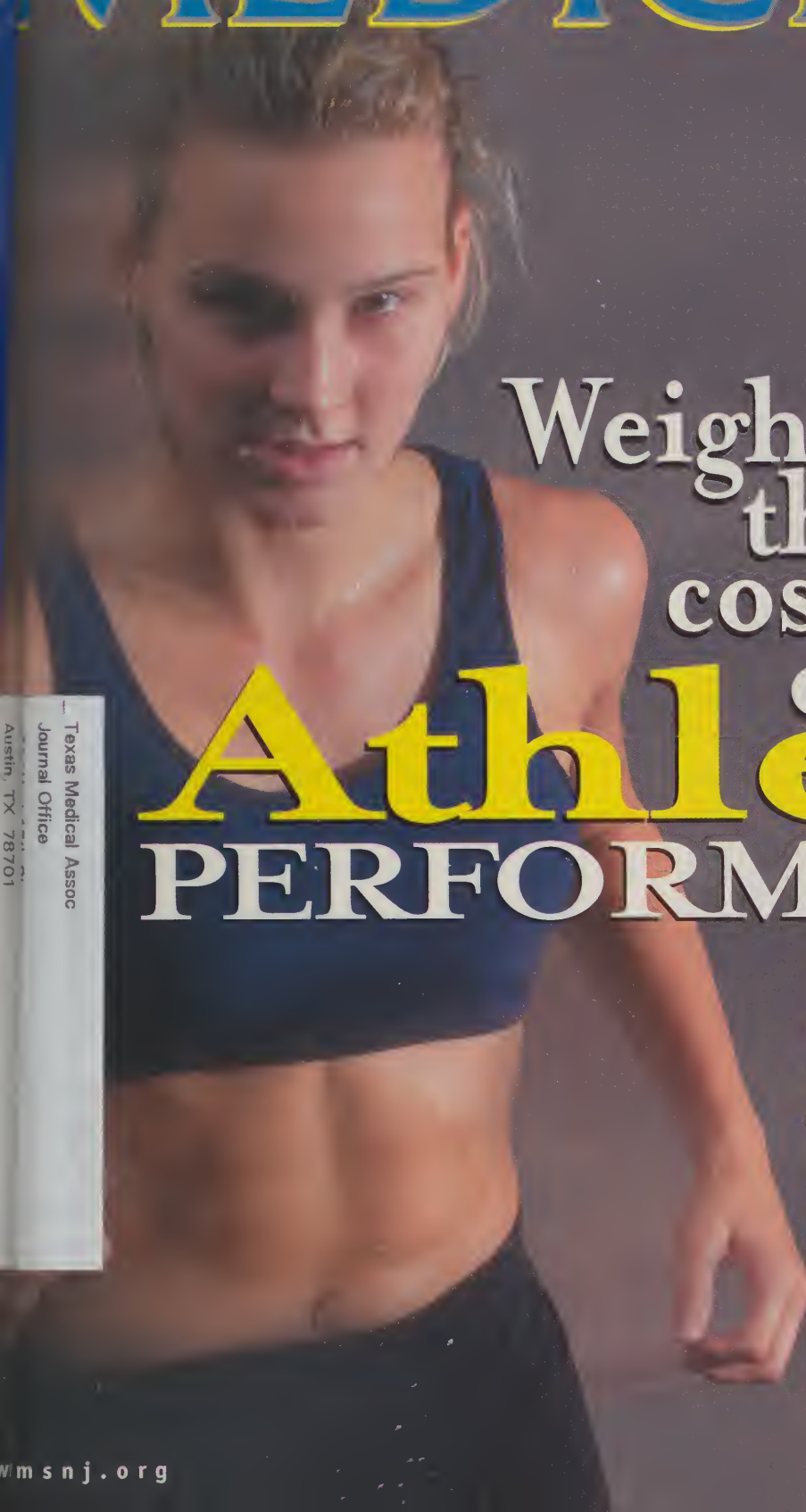


We welcome contributions to Photo Finish (color or black-and-white). Please include a 50-word description of the photograph. Send to Editor, New Jersey Medicine, Two Princess Road, Lawrenceville NJ 08648. Photographs will be returned.

NEW JERSEY MEDICINE

HEALTH CARE IN THE GARDEN STATE

OCTOBER 1998



Weighing
the
cost
of

Athletic PERFORMANCE

**Medicare
Audits**

*What are
your options?*

Texas Medical Assoc
Journal Office
Austin, TX 78701

Y - O - U - R

PRACTICE

MADE MORE

PERFECT

WITH OVERHEAD EXPENSE INSURANCE FROM BLANKSTEEN

If you get sick, we'd like to help keep your practice well with overhead expense coverage that can reimburse office salaries, rent, insurance premiums, and utilities during an extended disability. Your needs are special, so call and talk with us. The only time to draw a blank in your insurance is when you fill it in with Blanksteen.



The ----- steen Companies

The Blanksteen Companies 253 Washington Street Jersey City, NJ 07302 201-333-4340 1-800-BLANK-AG
The Blanksteen Companies 161 William Street New York, NY 10038 212-732-9435 1-800-BLANK-AG
The MEDICAL SOCIETY OF NEW JERSEY endorsed plans, including Professional Overhead Expense underwritten by National Casualty Company.

Playing politics with health care

New Jersey state Board of Medical Examiners (BME) president and MSNJ member Bernard Robins, MD, has launched an initiative to establish a BME biomedical ethics committee. Dr. Robins's action could dramatically move BME to a position of national leadership in end-of-life care. Until recently, BME appeared to many observers to stand in the way of patients' decisions to avoid heroic medical efforts at the end of life.

BME's new committee is expected to address concerns involving do-not-resuscitate orders, pain management, and genetic testing. Boards in other states have not set up committees to explore the biomedical thicket.

Led by second vice-president Angelo S. Agro, MD, MSNJ officials enthusiastically backed the move. MSNJ has long been a leader in biomedical issues.

The parent company of Xact Medicare Services, New Jersey's

Medicare Part B carrier, has agreed to pay \$38.5 million to the federal government to resolve numerous Medicare-related allegations. Criminal charges also are being brought against a former official of the parent company's predecessor, Pennsylvania Blue Shield.

According to the Medicare/Medicaid Reimbursement Alert of the Bureau of National Affairs, the allegations include lying to federal regulators, obstructing audits, failing to process legitimate claims, and failing to recover overpayments. Xact is being replaced as the Part B carrier for New Jersey by Empire Blue Cross.

Preserving its status as a generous contributor to causes that benefit other states, New Jersey ranked 49th last year in return on the federal tax dollar. The state received 69 cents from the federal government for every dollar paid by state residents in federal taxes.

Connecticut ranked last in the survey, conducted by the Northeast-Midwest Congressional Coalition. In past years, the

Garden State sometimes has occupied this bottom honor slot, and New Jersey's performance has been consistent.

Factors chiefly responsible for New Jersey's poor showing include high per capita income, low poverty rates, and lack of military installations. The state's senior U.S. senator, Frank Lautenberg, responded to the news by calling for more federal grants and fewer

Congressman Greg Ganske, MD, an Iowa Republican, rose on the floor of the House of Representatives to say, "Mr. Speaker, opponents of strong patient protection legislation, may succeed in preventing reform legislation from passing this year. But I guarantee you, Mr. Speaker, this issue will only get hotter in the coming years if Congress doesn't act to truly curb the abuses of some health maintenance organizations."

"wasteful subsidies that benefit the large mining companies, oil companies, cattlemen, and other special interests."

More pointedly, Senator Robert Torricelli blamed "a Congress increasingly dominated by rural southern Republicans." He may be wrong; several Republican con-

gressional leaders represent suburban districts.

Neither Mr. Lautenberg nor Mr. Torricelli is up for re-election on November 3. All New Jersey incumbent members of the House of Representatives are candidates for re-election. The roster includes Representatives Rob Andrews (D-Haddon Heights), Frank LoBiondo (R-Vineland), Jim Saxton (R-Mount Holly), and Chris Smith (R-Hamilton), from the 1st through 4th districts, respectively.

Some other congressional re-election hopefuls are Marge Roukema (R-Ridgewood), Frank Pallone, Jr (D-Long Branch), and Bob Franks (R-New Providence), from the 5th through 7th districts, respectively. Congresswoman Roukema is a previous winner of both the American Medical Association's Dr. Nathan Davis Award and MSNJ's Palma E. Formica, MD, Women in Medicine Award.

The list also includes, from the 8th, 9th, and 11th districts, Bill Pascrell, Jr (D-Paterson), Steve Rothman (D-Fair Lawn), and Rodney Frelinghuysen (R-Morristown), who weighed in with his own solution for improving New Jersey's dollar ranking, "lowering the tax burden." The 12th

district's Mike Pappas (R-Rocky Hill) is another New Jersey congressman facing re-election.

All candidates named here appear to enjoy strong support among MSNJ members.

Physicians and other folks interested in health care will do well to participate in the political process. You can be sure that your competitors play their part.

Within three years, 80 percent of surgical operations will be performed in outpatient departments or ambulatory care settings, predicts a *MedPro Month* article summarized in the *Healthcare Leadership Review*. BME has taken the lead in efforts to regulate ambulatory surgery more stringently. Hospitals in the state are seeking to preserve their surgical market share.

Yet, the decline in inpatient care has slowed and may have ended, according to another *MedPro Month* and *Leadership Review* piece. Analyzing American Hospital Association data, the writers note a nationwide increase in admissions of 0.7 percent in 1997, following a drop the year before.

Also, the decline in hospitals' average lengths of stay is leveling off. These trends principally reflect the aging of the population and may produce an increase in

total inpatient days this year, for the first time in the 1990s. The trends demonstrate the difficulty of holding down health care costs, through managed care or any other system, in the face of rising demand for health services.

Acquisition is giving way to affiliation as the preferred strategy of physician practice management (PPM) firms, reports *Physician Manager* in another *Leadership Review* item. Affiliation is attractive to the PPM sector, because it does not generate huge debts and a dependency on large profits.

In addition, affiliation allows a PPM company to be more nimble and to offer selected services to physician group practices. Affiliation also may reduce exposure to state regulators.

Needle exchange now is the big issue in preventing HIV infection related to intravenous drug use. Often overlooked, though, is the need to bring more users into drug treatment. This lapse occurs both in Trenton and in Washington, where the federal drug czar, General Barry McCaffrey, recently chided Congress for failing to increase funding for drug abuse treatment. "It clearly works better than locking people up," commented the czar.

Neil E. Weisfeld

“I KNOW NO
WAY OF JUDGING
THE FUTURE
BUT BY THE PAST.”



As a Princeton Insurance Company policyholder, your professional and financial future isn't written in the stars, but in the history books: Princeton has had a long-standing commitment to meet the professional liability insurance needs of doctors. That includes a track record of vigorously defending our insureds against frivolous malpractice claims and a rate structure that rewards doctors with good experience.

To help secure *your* future, consult one of the independent agents who represent Princeton or call us at 1-800-433-0157.



Princeton Insurance Company

Professional Liability

Office Package Policy

Workers Compensation

Rated A- (Excellent) by A.M. Best Company 746 Alexander Road • Princeton, New Jersey 08540

NO SWEAT.



It may seem like brain surgery, but creating messages that attract attention and generate results is our specialty, and we do it well. So, whether you're hoping to develop your practice, or trying to reach physicians and others, call us. We'll give your budget a workout, without breaking a sweat.



THREE BEARS

ADVERTISING • MARKETING COMMUNICATIONS

20 NASSAU STREET, PRINCETON, NJ 08542
609-688-1400

New Jersey Medicine (ISSN-088-5842-X) is published monthly (since 1904) under the direction of the Council on Communications by the Medical Society of New Jersey (MSNJ), Two Princess Road, Lawrenceville, NJ 08648. Printed in Lancaster, PA, by Lancaster Press. Printed in USA. Whole number of issues 1132. Member's subscription (\$10) is included in MSNJ dues. Rates for nonmembers are \$50; outside USA, add \$20. Single copy is \$7.50. Periodicals postage paid at Trenton, NJ, and Lancaster, PA. Copyright 1998 by MSNJ. October 1998. Internet address: <http://www.msnj.org>. E-mail address: info@msnj.org. 609.896.1766. FAX 609.896.1368. Postmaster: Send address changes to *New Jersey Medicine*, Two Princess Road, Lawrenceville, NJ 08648. The appearance of advertising *New Jersey Medicine* is not a MSNJ guarantee or endorsement of the product or service, by the advertiser. When MSNJ has endorsed a product or program, that will be expressly noted.

NEW JERSEY MEDICINE

OCTOBER 1998

Editor-in-Chief Howard D. Slobodien, MD
Executive Editor Geraldine R. Hutner, MA
Assistant Editor Nancy M. Propsner, BA
Editorial Assistant Karen Cuozzo, BS
Advertising Cookson Media Services
Ritchie Resource Group
Production Trenttypo, Inc.
Graphic Design Three Bears Communications
Cover: Conrad Gloos

President and Chair R. Gregory Sachs, MD
President-Elect Irving P. Ratner, MD
First Vice-President Walter J. Kahn, MD
Second Vice-President Angelo S. Agro, MD
Secretary Bessie M. Sullivan, MD
Treasurer Eileen M. Moynihan, MD
Immediate Past-President Carl Restivo, Jr, MD

MEDICAL SOCIETY OF NEW JERSEY BOARD OF TRUSTEES

S. Manzoor Abidi, MD
Stevan Adler, MD
Churchill L. Blakey, MD
Donald J. Cinotti, MD
Rajendra Prasad Gupta, MD
George T. Hare, MD
David A. Ingis, MD
Philip J. Jasper, MD
Elliot M. Kraus, MD
Giovanni Lima, MD
Mark T. Olesnick, MD
Robert S. Rigolosi, MD
Andrew Kunish, MD, *Speaker of the House*
John W. Spurlock, MD, *Vice-Speaker of the House*
Francis J. Lumia, MD, *OMSS*
Jamsheed K. Najmi, MD, *Medical Specialty Societies*
Sean C. Reinhardt, *Medical Student*
Niranjan V. Rao, MD, *Member-at-Large*
Michael J. Spedick, MD, *Member-at-Large*
Valerie Claps, *MSNJ Alliance*
Carlo Porcaro, MD, *IMG Section*

COUNCIL ON COMMUNICATIONS

Charles M. Moss, MD, *Chair*, Harry M. Carnes, MD, *Vice-chair*,
Henry R. Liss, MD, *Vice-chair*, Richard M. Ball, MD,
John P. Capelli, MD, Paul J. Carniol, MD,
Andrew B. Covit, MD, Anthony Del Gaizo, MD,
Joseph A. Di Lallo, MD, Michael J. Doyle, MD,
Leigh Ende, MD, Steven C. Fiske, MD,
Jack Goldberg, MD, Daniel P. Greenfield, MD, MPH,
George H. Hansen, MD, M. Arif Hashmi, MD,
Christine E. Haycock, MD, Neil B. Horner, MD,
Monroe S. Karetzky, MD, Ismail Kazem, MD,
Louis L. Keeler, MD, Scott P. Keil, MD,
Joseph W. Kozielski, MD, Clement H. Kreider, Jr, MD,
Alan J. Lippman, MD, Robert M. MacMillan, MD,
George J. Mellendick, MD, MPH, Donald W. Orth, MD,
Robert M. Pallay, MD, Sindy M. Paul, MD,
Arthur W. Perry, MD, Niranjan V. Rao, MD,
Kelly M. Reid, MD, Carl Restivo, Jr, MD,
John D. Slade, MD, Leon G. Smith, MD,
Julie E. Timins, MD, Sandra S. Valdez, MD,
Paul E. Wallner, DO, Richard A. Williams, MD,
Angelina Campo, Angelo S. Agro, MD,
Irving P. Ratner, MD, Howard D. Slobodien, MD,
Bessie M. Sullivan, MD, Matthew J. Stanton

The Morris-Somerset IPA, one of the oldest and largest IPAs in New Jersey, proudly announces its partnership with PhyCor/North American Medical Management for the purposes of acquiring and effectively managing risk contracts with area payers.

All payer and provider inquiries are welcome.
Please call the MSIPA office at (973) 292-9496.

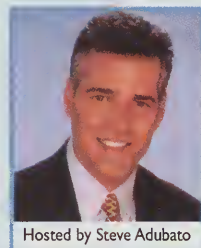
**Ask the right questions...
Make the right choices...**



Watch this special
Caucus: New Jersey public television series and get the information you need to make informed health care decisions for you and your family.

Informed Choices

caucus
NEW JERSEY
www.caucusnj.org



Funded by:

THE
ROBERT WOOD
JOHNSON
FOUNDATION

Caucus: New Jersey is a co-production of the Caucus Educational Corporation, Rutgers-Newark, NJN-Public Television and Thirteen/WNET.



Thirteen/
WNET



NJN-
Public Television

Care and Caring at the End of Life

Saturday 10/3 at 12:30pm
Sunday 10/4 at 6:00am

Sunday 10/4 at 10:00am
Wednesday 10/7 at 6:30pm

Teen Smoking

Saturday 10/10 at 12:30pm
Sunday 10/11 at 6:00am

Sunday 10/11 at 10:00am
Wednesday 10/14 at 6:30pm

Good Health, Good Choices

Saturday 10/17 at 12:30pm
Sunday 10/18 at 6:00am

Sunday 10/18 at 10:00am
Wednesday 10/21 at 6:30pm

Doctors and Patients

Saturday 10/24 at 12:30pm
Sunday 10/25 at 6:00am

Sunday 10/25 at 10:00am
Wednesday 10/28 at 6:30pm

TEXAS MEDICAL ASSOC. LIBRARY

OCT 19 1998

AUSTIN, TEXAS

NEW JERSEY MEDICINE

HEALTH CARE IN THE GARDEN STATE

October 1998

28

Focus on health care

Weighing the cost of athletic performance

By Karen Cuozzo

An increasing number of women are participating in athletic programs. Are they at risk of developing the female athlete triad?

35

Special feature

Living longer

By Bill Berlin, PhD

Longevity has increased at a remarkable rate in the 20th century, with major advances in public health and medical care.

41

Public health advances

Post-traumatic stress disorder:

Healing the hidden traumas

By Sheila Smith Noonan

Post-traumatic stress disorder occurs in 5 percent of men and 10 percent of women. Is the medical profession taking notice?

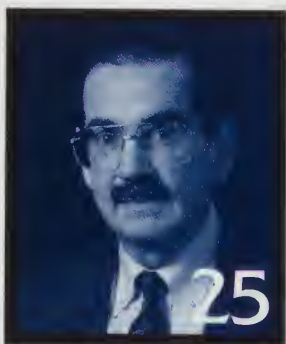
45

Clinical report

Symptomatic pulmonary nodule in a youth: CME activity

By David G. Landsnes, MD; Randall L. Siegel, MD;
Melissa Chen, MD; John L. Noshier, MD

A young male presents with hemoptysis and a pulmonary nodule on chest radiography. The findings are in this CME activity.



R. Gregory Sachs, MD,
on practicing medicine today.



Kelly Reid, MD,
on post-traumatic stress disorder.



Richard Lehman, MD,
on pallidotomy.

Our medical specialists make a practice of creating solutions for physicians like you.

Summit Bank's Healthcare Financial Services Group features some of the finest medical specialists in New Jersey. They understand your industry and the issues facing it. As New Jersey's largest locally headquartered bank, our professionals are specifically devoted to the healthcare industry. That means our customized solutions — from loans to leases — come with something extra: time-tested expertise. If you'd like, we'll even help you find a more efficient way to run your practice. To find out more, call Norm Buttaci, Regional Vice President, 609-987-3561.



Summit, Summit Bancorp and Reach Higher are registered service marks of Summit Bancorp • Summit Bank is a service mark of Summit Bancorp.

55 In the spotlight

Interview with Richard Lehman, MD

By Diane Haring Cornell

MSNJ member Richard Lehman, MD, is one of the few neurosurgeons in the country performing pallidotomy.

59 Financial matters

Maximizing your assigned insurance receivables

By Neal B. Schultz, MD

A professional billing company allows a physician to effectively manage medical billing and to concentrate exclusively on patient care.

61 Law, medicine & ethics

Medicare audits by the numbers

By Steven I. Kern, Esq

Medicare audits of a physician's practice should be conducted under the direct auspices of health care counsel.



The New Jersey Vietnam Veterans' Memorial is a reminder of the hidden trauma of post-traumatic stress disorder.

DEPARTMENTS

1 Newswatch

BME and biomedical ethics. New Jersey elections and taxes.

10 Mail Stop

HIV counseling and testing. Who are the uninsured? Plenty of plantain.

17 F.Y.I.

Out-of-pocket expenses. Medical loss ratios. Pursuing quality.

19 Editor's Notes

There is a need to let the experts offer solutions to the war on drugs.

23 Online @ MSNJ

Attending to an SOS. High achievers. Physician workforce progress.

25 MSNJ News

The practice of medicine today, according to MSNJ President R. Gregory Sachs, MD.

64 Calendar

Current listing of medical meetings and conferences around the state in the fall.

72 Photo Finish

October is Domestic Violence Awareness Month. Take note of its importance.

YOUR PRACTICE HAS CHANGED SIGNIFICANTLY. SO WHY HASN'T YOUR PRACTICE INSURANCE?

Traditional policies for medical practices are not tailored for you. In fact, the same insurance policy you currently use covers everything from a shoe store to a pizza parlor. Does that sound logical?

The Woodland Group has changed the concept of insuring a medical practice. Today, your medical practice can be protected by The Woodland Alliance Profile, a Risk Management Group created exclusively for physicians offering . . .

- Practice-specific coverage that has and will continue to evolve as the medical industry changes, covering everything from office property and patient charts to diagnostic equipment, general liability and workers' compensation.
- An opportunity to share in profitability of the Risk Management Group through profit sharing returns.

Put Yourself in the Hands of a Specialist.

Call us at **1-800-253-1521** to learn more about The Woodland Alliance Profile or check our website at **www.woodlandgroup.com**.

The Woodland Alliance Profile...
coverage that is as evolutionary
as your practice.



- Medical Malpractice
- Managed Care Liability
- Group Disability
- Group Term Life
- Homeowners/
Automobile

1-800-253-1521

<http://www.woodlandgroup.com>



HIV counseling and testing

We are responding to the letter, "In-office HIV testing" in the May 1998 issue of *New Jersey Medicine*. The New Jersey Department of Health and Senior Services (DHSS) supports access to HIV counseling and testing for virtually all patients. Clearly, many persons are unaware of their risk. People who are sexually active, even in supposedly monogamous relationships, may be affected because of their sexual partner's exposure. If testing is limited to certain "risk groups" or to those who have knowingly engaged in behaviors considered high risk for HIV transmission, some persons infected with HIV will not be identified.

In 1995, New Jersey passed a law requiring mandatory counseling and voluntary testing of pregnant women (N.J.A.C. 8:6-3.1). Making HIV counseling and testing a routine part of examinations removes the stigma attached to such testing. The Food and Drug Administration (FDA) approved the diagnostic HIV antibody tests using blood, oral transmemucosal exudate, or urine, to make the test easier.

HIV testing should be accompanied by information about preventing the acquisition and transmission of HIV, and informed consent. Physicians must protect

the confidentiality of tested patients (N.J.A.C. 26:5C), and give test results and post-test counseling in person, only to the patient. If the result is nonreactive, post-test counseling should include repetition of education about prevention of HIV acquisition and the need for future retesting. If the results are indeterminate, plans for followup testing or referral, as appropriate, should be made, emphasizing prevention of HIV transmission. If the patient is HIV positive, the patient should receive medical care, preferably by a physician with experience treating HIV-infected patients, and be referred to prevention services. Physicians are required to report patients who are HIV positive to DHSS (N.J.A.C. 8:57-2.1-2.7).

Insurance companies cannot cancel policies for individuals seeking counseling, regardless of HIV serostatus. Employees entitled to COBRA who lose their group health insurance due to reduced working hours or termination,

must be offered the option of buying group coverage for a limited period. If HIV infected, this employee can apply for assistance through DHSS, Health Insurance Continuation Program (HICP). HICP will pay monthly premiums for COBRA or individual plans, for financially eligible applicants. Information on HICP can be obtained by calling 609.984.6125 or on the DHSS web site at www.state.nj.us/health.

DHSS funds programs throughout the state to provide free, confidential counseling and testing. These groups report test results to a referring physician, provided the patient signs a medical information release. More information about counseling and testing sites can be obtained from DHSS 609.984.6125 or www.state.nj.us/health.

Sindy M. Paul, MD, MPH

Laurence Ganges, MSW

Helene Cross, MA

Trenton

The uninsured

I was amazed to find in a feature article, "Who Are the Uninsured?" (*New Jersey Medicine*, July 1998), not even a mention of the most logical solution to the problem: a system of universal health care.

I recommend to *New Jersey Medicine* readers a new book on the Canadian system of health care, *Universal Health Care: What the United*

Requirements for letters

To submit a letter, fax (609.896.1368), e-mail (info@msnj.org), or mail your letter to *New Jersey Medicine*, Two Princess Road, Lawrenceville NJ 08648. Letters should be typed and double-spaced and should be no longer than 400 words with 4 references, if necessary. Include your full name, affiliation, address, and telephone number.

Letters are published at the discretion of the editor-in-chief and are subject to editing and abridgment. Letters may be published on MSNJ's web site, <http://www.msnj.org>. Financial associations or other possible conflicts of interest must be disclosed. Letters represent the opinions of the authors.

Comprehensive Care for Your Financial Health

M. Sanders & Associates is a full service, all inclusive medical billing, collection and consulting company. We offer professional services to increase your bottom-line profitability by maximizing your reimbursement and improving your productivity.

M. Sanders & Associates has a variety of services available both individually or in combination packages. We can also customize services specifically to meet the needs of your medical practice.

Call Regina Rudd at (609) 661-8011, to arrange for a complimentary consultation and office assessment.

M. SANDERS

ASSOCIATES

Billing, Collection & Consulting Services

A COLLECTIVE WAY TO RESOLUTION

LIFSHUTZ, POLLAND & ASSOCIATES, P.C.

THE LAW FIRM THAT SPECIALIZES IN HEALTH CARE REPRESENTATION OF PHYSICIANS AND OTHER HEALTH CARE PROFESSIONALS.

OUR AREAS OF EXPERTISE INCLUDE:

1. Managed Care Contracts with MSOs and HMOs.
2. Health Care Mergers/Joint Ventures/Acquisitions.
3. Development and implementation of Compliance Audits and Plans.
4. Respresentations in Board of Medical Examiner Cases.
5. Asset Protection/Estate Planning as protection against malpractice suits.
6. Federal and State Anti-Kickbacks/Stark/Safe Harbor representation.
7. Medicare/Medicaid/Third Part Audits

OUR EXPERT STAFF CONSISTS OF SPECIALIZED ATTORNEYS AS WELL AS PHYSICIAN-ATTORNEYS.

LIFSHUTZ, POLLAND & ASSOCIATES, P.C.

ATTORNEYS AT LAW

76 SOUTH ORANGE AVE., SO. ORANGE, NJ 07079
(973) 275-5009

675 THIRD AVENUE, NEW YORK, NY 10017
(212) 949-8484

<http://www.lifshutz-polland.com>

NEW JERSEY RESIDENTS: DOUBLE-TAX-FREE INCOME

100% NO LOAD

YIELDS
7.13%

Tax-equivalent
36% tax rate

4.27%

Current
30-day yield
as of 8/31/98

T. Rowe Price New Jersey Tax-Free Bond Fund is ranked #2 out of 16 funds in the Lipper New Jersey Municipal Debt Category since its inception (4/30/91) for the period ending 6/30/98.* This fund invests primarily in long-term New Jersey municipal securities, so the income it offers is double-tax-free. *You pay no state or federal tax on your investment earnings.*** Proprietary credit analysis and active management help reduce risk. Of course, the fund's yield and share price will fluctuate as interest rates change.

With no sales charges, all your money works for you. The fund is 100% no load. And, since there are no broker fees—which can eat up as much as 5% of your principal—all your money gets invested. \$2,500 minimum. Free checkwriting.†

Call 24 hours for a
free report and prospectus

1-800-541-4518

www.troweprice.com

Invest With Confidence®
T. Rowe Price



34%, 5.86%, and 7.85% are the fund's 1-year, 5-year, and since inception (4/30/91) average annual total returns, respectively, for the periods ended 6/30/98. Figures are changes in principal value, reinvested dividends, and capital gain distributions. Investment return and principal value will vary, and shares may be worth more or less at redemption than at original purchase. *According to Lipper Analytical Services, Inc., which ranked T. Rowe Price New Jersey Tax-Free Bond Fund #9 out of 57 for the 1-year period ended 6/30/98. **Some income may be subject to the federal alternative minimum tax. Income earned by non-New Jersey residents will be subject to applicable state and local taxes. \$2,500 minimum. Past performance cannot guarantee future results. Read the prospectus carefully before investing. T. Rowe Price Investment Services, Inc., Distributor. NJB044324



UNPRECEDENTED ACCOUNTABILITY
CONFLICTING PERFORMANCE CRITERIA
MULTIPLE, FRAGMENTED PROCESSES
TIME-CONSUMING
MORE DOCUMENTATION
LESS PATIENT CARE
HIGH COST
DUPLICATIVE OFFICE-SITE REVIEWS
INCONSISTENT CREDENTIALING
NEVER-ENDING PAPERWORK
ADMINISTRATIVE HASSLES

Our solution has arrived.

One Time

One Source

One Standard



American
Medical
Accreditation
Program

With the new American Medical Accreditation Program (AMAP), physicians complete an application **ONE TIME**, have their credentials primary-source verified **ONE TIME**, and have an on-site office review **ONE TIME**.

AMAP then provides an Accreditation report and certificate to each physician who meets the AMAP national standard.

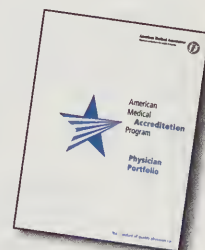
AMAP will provide a complete portfolio of verified credentials, office site review and other frequently requested information to each health plan and hospital that uses AMAP and with whom the physician is affiliated.

American Medical Accreditation Program is a voluntary, comprehensive accreditation program that measures and evaluates individual physicians against national standards, criteria and peer performance in five areas: Credentials, Personal Qualifications, Environment of Care, Clinical Performance, and Patient Care Results.

Meeting and maintaining AMAP's high standard earns a physician AMAP Accreditation – a new national benchmark of physician quality.

AMAP, your one source for the new national standard of physician quality information, has arrived.

To learn more about the many benefits AMAP has to offer *your* organization, call the AMAP Resource Center at 1-888-881-AMAP (2627) or visit the AMAP Web site at <http://www.ama-assn.org>.



The standard in quality physician care.

American Medical Association
Physicians dedicated to the health of America



States Can Learn from the Canadian Experience. Succinctly, with considerable documentation, its authors describe the features of how medicine is practiced in the democracy to our north. All Canadian citizens have access to basic medical care paid for out of general tax revenues, administered by provincial governments. Everyone can pick their own physician, who is reimbursed promptly for 100 percent of the work on a fee-for-service basis. Fees are determined yearly by negotiations between physician organizations and the government. Paperwork is minimal, and physicians are the final arbiters of clinical decisions. A lower cost per patient in relation to gross national product succeeds in keeping Canadians as healthy as citizens in the United States. Physician incomes in Canada are comparable to those in the United States on average. The system is strongly endorsed by a great majority of patients and doctors.

The authors of this book recount the history of the Canadian system. It began in the 1970s in one province, Saskatchewan, and gradually was adopted by other provinces. I realize the enormous political and administrative obstacles that must be overcome to establish such a system, but maybe its time is coming in view of the increasing dissatisfaction with what

is happening here now. Could it be more than an idle daydream of mine that New Jersey would enact a form of universal health care, prove its feasibility and efficacy over a period of several years, and lead the way to its adoption throughout the nation?


Norman J. Sissman, MD
New Brunswick

Plenty of plantain

I'm writing in defense of plantain. Your "Editor's Note" in the August 1998 issue states that "digitalis also is found in plantain." My copy of *Worst Pills Best Pills* makes no reference to plantain. New Jersey Poison Control informed me that plantain contains no digitalis and is not poisonous. Plantain has an interesting history. It derives its name from the Latin "planta" (sole of the foot) as does plantar fascia and plantar warts. According to legend, it grows wherever a Roman legionnaire placed his foot. Because of this, it also acquired names such as white man's foot and Englishman's foot.

Tell Herb that this herb is delicious in salads, a superb boiled green, rich in potassium, low-caloric, cholesterol-free, a laxative for the constipated, costs nothing, and digitalis free. Don't sell it short.

Albert P. Rosen, MD
Fair Lawn

Editor's reply: Space did not allow more than brief references to source materials in my editorial. Here are expanded quotations from the August 1997 issue of *Worst Pills Best Pills*, edited by Sidney M. Wolfe, MD: "The FDA now is warning consumers not to buy or take dietary supplement products containing plantain because these products may also contain digitalis. . . . The FDA detected digitalis in samples of raw material labeled plantain that has been used by various manufacturers as an ingredient in dietary supplement products . . . In addition, some of the suspect plantain has been distributed to retailers who sell the product in bulk for making tea. . . . This plantain should not be confused with the tropical fruit of the same name. . . . The FDA has listed more than 130 distributors and shops nationwide who sell products with plantain in leaf, powder, or bulk form that may contain digitalis." But thank you for writing. How about an article for *New Jersey Medicine*? 

Requirements for letters

To submit a letter, fax (609.896.1368), e-mail (info@msnj.org), or mail your letter to *New Jersey Medicine*, Two Princess Road, Lawrenceville NJ 08648. Letters should be typed and double-spaced and should be no longer than 400 words with 4 references, if necessary. Include your full name, affiliation, address, and telephone number.

Letters are published at the discretion of the editor-in-chief and are subject to editing and abridgement. Letters may be published on MSNJ's web site, <http://www.msnj.org>. Financial associations or other possible conflicts of interest must be disclosed. Letters represent the opinions of the authors.

To increase cash flow, simply remove the tail.

Most New Jersey malpractice insurance policies require you to purchase a reporting endorsement — known as a tail — to protect against claims that may occur during retirement. B.C. Szerlip offers a unique policy from an A+ rated company that does not include an annual tail premium. In fact, if you maintain coverage with us until retirement, you'll *never* have to purchase a tail, and you'll still be protected.

That's just one example of the creative ways that B.C. Szerlip has discovered to help doctors with their long-range financial planning.

At B.C. Szerlip, we take a big-picture view of your practice, offering you comprehensive insurance and financial planning services. You can benefit from our nearly two decades of experience providing malpractice insurance for medical offices both large and small. In addition, our financial planners can offer strategic guidance for the overall health of your business affairs, so you can stay focused on the health of your patients.

We'd like to give you a taste of our full-service approach by sending you *The Managed Care Survival Kit for Physicians*. To receive your complimentary copy of this useful guide, please call us at 800-684-0876.

BCSZERLIP

INSURANCE AGENCY INC.

99 WOOD AVENUE SOUTH, PO BOX 217

ISELIN, NJ 08830-0217

800-684-0876 • 732-205-9800

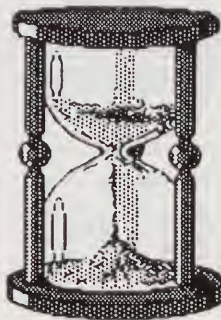
FAX: 732-205-9496

E-MAIL: bcszerlip@aol.com

*Professional Insurance Services
for Health Care Providers*

TIME.

Staffing,
Hiring, Training,
Phone Etiquette
Billing,
Patient Flow
Insurance,
CPT & ICD Coding,
all take time to
coordinate effectively.
All critical decisions.
Is your staff working
up to expectations?



Do you have coding problems? Call one number for a complete turn-key approach, assuring peak performance in your office. Your medical practice is a business, and if that business does not run efficiently, it will affect your patient and public relations.

YOURS IS VALUABLE. SAVE IT! REORGANIZE!

MARY ANN HAMBURGER

A S S O C I A T E S

THE SPECIALIST'S SPECIALIST

74 HUDSON AVE. MAPLEWOOD, N.J. 07040

973-763-7394

NOTICE ON V.E.B.A.'S

**THE U. S. TAX COURT UPHELD
VEBA LEGALITY AND TAX-
PAYER RIGHTS TO REDUCE
TAXES AND SECURE OTHER
BENEFITS THROUGH TAX
DEDUCTIBLE CONTRIBUTIONS.
VEBA CONTRIBUTIONS ARE
SEPARATE FROM, AND ARE NOT
PRE-EMPTED BY, PENSION
CONTRIBUTIONS.**

**BOOTH V. COMMISSIONER,
6/17/97 JUDGE S. LARO**

THE KIRWAN COMPANIES

402 Middletown Blvd., Ste. 202 Langhorne, Pa. 19047
(215) 750-7616 (215) 750-7791 Fax

Critical Treatment for the Future of Your Practice...



Before It's Too Late

Wilentz, Goldman & Spitzer's Health Care Law Practice Group serves health care professionals regarding: group practice formation and operations; management service organizations (MSOs); physician practice management companies (PPMCs); managed care contracting; physician-hospital organizations (PHOs); independent

physician associations (IPAs); restrictive covenants; and regulatory, employment, tax and litigation matters. **Think of us as preventive medicine for your practice.** For information please call our Health Care Law Practice Group Co-Chairs: Michael F. Schaff at (732) 855-6047 or Francis V. Bonello at (732) 389-5636.

WILENTZ
GOLDMAN
& SPITZER
ATTORNEYS AT LAW

"Helping The Health Care Professional"

Woodbridge, NJ • Eatontown, NJ • New York, NY

<http://www.newjerseylaw.com>

PEOPLE IN THE NEWS



Patrick J. Zenner

Patrick J. Zenner has been elected chair of the HealthCare Institute of New Jersey Board of Trustees, New Brunswick.

Elin Gursky, ScD, is vice-president of public health, St. Barnabas Health Care System.



Elin Gursky, ScD



George H. Hansen, MD

MSNJ member **George H. Hansen, MD**, has been named medical director at Capital Health System, in Trenton.

OUT OF POCKET EXPENSES

Xact Medicare Services has identified overpayments made to certain providers who incorrectly reported new patient ophthalmological procedure codes. This is for claims finalized from August 1, 1994, through February 28, 1997.

These physicians reported more than one new patient procedure code per beneficiary within a three-year time period. According to Medicare guidelines, only one new patient ophthalmological service (codes 92002 and 92004) is eligible for reimbursement within three years. Subsequent ophthalmological services within three years of the new patient exam should be reported using the established patient codes (92012 and 92014). The refund requested will be the difference in payment between a new and established patient exam.

Please contact Patricia Bucek (717.730.5898) or Gail Rounds (609.896.0670) with any questions about reimbursement.

PURSuing QUALITY

Emmy Award-winning commentator Steve Adubato (standing) moderates a panel discussion on quality care initiatives sponsored by the New Jersey Health Care Quality Institute. Panelists representing industry and consumer groups are (seated l to r): Nataly M. Evans, director, Organizing for Community Development; Paul Langevin, president, NJ Association of Health Plans; David L. Knowlton, vice-president, MIIX HealthCare Group; Alfred Tallia, MD, associate professor, UMDNJ-Robert Wood Johnson Medical School; Bryan Markowitz, director of Health Affairs, New Jersey Business & Industry Association; and Justin Doheny, executive vice-president, St. Peters Medical Center.



1996 MEDICAL LOSS RATIOS

The MSNJ Board of Trustees presents the following latest available information on the expenditure of premium dollars and the percentage spent on patient care versus administrative overhead and profit margin of insurance and managed care companies.

HMO	All monetary figures in \$000			Loss Ratio	Medicaid Revenue	Loss Ratio	Overall Loss Ratio
	Commercial Premium	Loss Ratio	Medicare Revenue				
Aetna Health Plans	178,851	79.0%	63,882	115.9%	0		88.7%
Americaid NJ Inc.	0		0		13,938	85.0%	85.0%
American Preferred	0		0		31,507	76.9%	76.9%
Amerihealth HMO	68,269	83.5%	10,722	99.2%	9,964	96.8%	86.3%
Atlanticare Health Plans	0		0		0		
ChubbHealth	717	79.8%	0		0		79.8%
Cigna NJ	12,998	75.9%	0		0		75.9%
Cigna North/Comed	126,425	73.7%	0		0		73.7%
Community Healthcare Plan	0		0		1,695	79.9%	79.9%
First Option Health Plan	212,646	93.0%	13,277	97.7%	23,301	102.7%	94.2%
Harmony Health Plan	6	2966.7%	0		24,900	83.2%	83.9%
HIP Health Plan	271,745	92.6%	50,827	83.7%	34,917	95.3%	91.6%
HMO Blue	246,331	83.3%	16,593	89.0%	101,125	96.7%	87.3%
Liberty Health Plan, Inc.	252	78.6%	0		20,699	81.3%	81.2%
Managed Healthcare System	0		0		31,266	80.0%	80.0%
MetraHealth Upstate NY	569	56.1%	0		0		56.1%
NYLCare Health Plans	60,716	89.2%	0		0		89.2%
Oxford Health Plans	257,847	74.7%	43,585	105.1%	37,612	64.7%	77.5%
Physician Health Plan	2,300	92.7%	0		0		92.7%
Physicians Health Svcs	3,309	73.0%	0		0		73.0%
Prudential Health Care	169,007	92.9%	0		0		92.9%
QualMed Plans for Health	2,742	77.4%	1,011	78.8%	0		77.8%
U.S. Healthcare	899,598	77.9%	160,925	89.3%	88,025	77.8%	79.5%
United HealthCare	35,922	91.8%	0		0		91.8%
University Health Plans	253	n/a	0		19,909	n/a	80.9%
Totals	2,550,503	82.4%	360,192	95.7%	438,818	85.1%	84.2%

You'll Benefit from this Benefit

MSNJ LEGAL CONSULTANT NETWORK

Three New Jersey law firms (*shown in sidebar*) have been carefully previewed and selected as charter members of the Medical Society of New Jersey Legal Consultant Network.

MSNJ members are entitled to register their engagement of any firm in the Network for professional services. MSNJ will monitor the engagement to assure that the MSNJ member, as a client, is satisfied with the services and that the engagement is working for the member's benefit.

To register the engagement, MSNJ members may contact Karen Monsees at MSNJ, 609/896-1766, extension 245.

The Network firms and areas that have been selected are valid for 1998.



**Kern Augustine Conroy
& Schoppmann, PC**
1120 Route 22 East
Bridgewater, NJ 08807
908/704-8585

- ▶ All areas of health law and physician representation

Timins, Larsen, Beacham & Hughes
85 Livingston Avenue
Roseland, NJ 07068
201/740-1771

- ▶ Employment and commercial law, ethics, health and other insurances, occupational safety and health, probate and real estate

Law Offices of Katherine Benesch
Princeton Pike Corporate Center
993 Lenox Drive, Suite 200
Lawrenceville, NJ 08648
609/844-7590

- ▶ All areas of health law pertaining to physicians

Medical Society of New Jersey
MSNJ

Metropolitan morality play

On August 14, 1998, New York City Mayor Rudolph W. Giuliani announced that heroin addicts treated in city hospitals would be allowed only three months of methadone maintenance. His rationale: methadone just substitutes one dependency for another, and abstinence is the only moral policy. He was backed by Dr. Luis R. Marcos, president of the Health and Hospitals Corporation, who said, comparing heroin addicts to alcoholics, "The expectation for the alcoholic is to be abstinent and the expectation for the heroin addict should have the same goal. . . . It's very easy and inexpensive to give a pill of methadone for life to people. But the time has come to liberate these addicts from that kind of expectation."

The handful of methadone-to-abstinence programs in New York has had few successes and these took longer than what the city administration proposes. More than 80 percent of addicts who stop methadone will relapse, often with severe physical, social,

and psychological problems. All the methadone-to-abstinence programs also offer standard, continuous treatment because of these dismal results. And there has been little investigation or evaluation of these efforts; we don't even know how to identify the addicts most likely to succeed.

Governmental officials, the National Institutes of Health, and scientists working in the field have

protested Giuliani's action. Even General Barry R. McCaffrey, drug policy chief in the Clinton administration, who opposes needle-exchange programs, has defended continuous methadone substitution. The mayor, true to his nature, lambasted these critics and said, "I think methadone is an enslaver. If you're going to keep somebody permanently enslaved to methadone for the rest of their lives, then I have

real questions about your common sense."

Giuliani and Marcos should pay attention to the first report of the Physician Leadership on National Drug Policy, which is highlighted in the April 15, 1998, *Journal of the American Medical Society*. It states, "Physician leadership on national drug policy finds addiction treatment works." The lead paragraph includes, "Addiction to illicit drugs can be treated with as much success as illnesses like diabetes, asthma, and hypertension. . . . This finding belies the popular belief that drug addiction carries a high failure rate. Moreover, mounting effective treatment programs for drug addiction may cost ten times less than putting addicts in prison."

Howard D. Slobodien, MD



**Every form of addiction
is bad, no matter whether
the narcotic be alcohol or
morphine or idealism.**

Carl Jung, *Memories,*

Dreams, Reflections, 1963

The Physician Leadership group has surveyed more than 6,000 peer reviewed articles and will make recommendations based on scientific evidence. It is long overdue; more than two-thirds of the public gets its knowledge of drug issues from the lay media—from entertainment and advertising segments as well as from news programs. As a result, people worry about crime, national character, morality, and impaired health as the major drug problems, but do not understand that effective treatment is possible, but is in short supply.

Addiction may not be anti-social, and substitution of a "lesser evil" may be worthwhile. We must educate the mayor about the interposition of less harmful bacteria for deadly coli and salmonella, and, perhaps most strikingly, the use of cowpox to prevent smallpox—a disease most of us have heard about, but never seen. How should we regard the use of nicotine patches and other devices to help smokers become non-smokers? These are not necessary evils; they are necessary aids. If one needs strong coffee to function at high efficiency, is that addict to be penalized? Is the charming afternoon tea ritual as a type of "pick-me-up" to be seen only in speakeasies?

Why does Giuliani feel that protracted, perhaps lifetime, use of a product to prevent unwanted ills is a bad thing? Does he decry the

**Under the pressure
of the cares
and sorrows of our
mortal condition,
men have at all times,
and in all countries,
called in some physical
aid to their consolations
— wine, beer,
opium, brandy,
or tobacco.**

*Edmund Burke, Thoughts and
Details on Scarcity, 1795*

long-term treatment of diabetes, asthma, and hypertension, as well as of COPD, migraines, and many other conditions? Should psychotics be returned to newly built or rebuilt mental institutions to wean them off their modern medications? Should disulfiram be disallowed for responding, recovering alcoholics? Should all over-the-counter aids for sleep be banned, and physicians restricted to a 30- or 90-day supply of antidepressants for any one individual?

Heroin, a morphine derivative, produces an ecstatic, glowing sensation in the addict, followed by relaxation, ease, and then clouding of intellect and attention. Methadone not only blocks the euphoria and the withdrawal effects in heroin addicts, when used for

maintenance it also blocks the mind's remembrance of that euphoria, which helps to prevent recidivism. It has no intrinsic euphoric effects of its own. Its long-term effects enable the users to lead normal, productive lives. Many experts in the field wish we had a similar product to treat cocaine addicts, whose habit tends to produce not only euphoria, but also excitement and paranoia. (If my memory is correct, the term "running amok" originated as a description of the actions of some Andean Indians who chewed the leaves of the coca plant.)

The real immorality is a failure to recognize the needs, not only of the addicted, but also of environment—peoples, cultures, and their surroundings. To paraphrase Frank Zappa, a drug is neither moral nor immoral—it's a chemical compound and not a menace to society until a human uses it as a license to act asocially. Although the treatment of addiction shows real progress, the overall war on drugs has been a failure, and its punitive aspects have caused some practitioners to short-change some of their patients. But the evaluation of this war, and its effects on the degree of abuse and the extent of criminal and black market activities should be left to scientific experts. One thing is certain—Rudy Giuliani is not one of them.

It could take years to become the boss. Or about three days.

Finance your own small business with a Preferred SBA Lender.

There are two ways to become the president of a company. You can work for years and years and slowly climb the corporate ladder. Or you can do it the fast way — by starting or buying a business with an SBA loan from Valley National. We're a Preferred SBA lender, so our approval process is very quick — usually three business days or less.

A loan can provide you with the financial base to get started, or to expand an existing business. And the monthly payments are very affordable. For a Commercial Property loan, you'll have up to 25 years to pay it back. You'll have up to 15 years to pay back an Equipment Loan, and up to seven years for a Working Capital Loan. All you have to do is call our toll free number or apply at any Valley branch. You're going to work hard either way. Why wait to become the boss?

1-800-SBA-6772

Valley National Bank

Member Federal Reserve System. Member FDIC.

An Equal Opportunity Lender. Preferred SBA Lender.

THE BANK THAT WORKS.SM

www.valleynationalbank.com

NORTH ARLINGTON NORTH CALDWELL NORTH PLAINFIELD

NORTHVALE NUTLEY OKLAND ORADELL PARAMUS

FRANKLIN FREDON F.L.L.E. GREEN BROOK HACKENSACK HACKETTSTOWN HANSON HILLSDALE HO-HO-KUS JEFFERSON TOWNSHIP KEANY LANDING LITTLE FALLS LIVINGSTON LINDHURST MAPLEWOOD MIDLAND PARK MINE HILL MOONSHINE MORRIS PLAINS NEW MILFORD NEWARK

© 1998 Valley National Bank



Stuart M. Hochron, M.D., Esq.

Physician Legal Representation

- Group Practice Formation
- Physician Litigation
- Federal Regulation
- Board of Medical Examiners

Practicing Physician, Twenty Years

Clinical Professor, UMDNJ-RWJMS
Research as Highlighted on CNN
AMA Physician Referral Service
Partner, Richmond, Hochron & Burns



phone: (732) 821-0200 fax: (732) 422-9444 e-mail: MDLAWSMH@aol.com

209 North Center Drive North Brunswick, New Jersey 08902

ENDING TO AN SOS

In a medical emergency, access to a patient's allergies, medical conditions, and medications can prevent serious consequences like misdiagnosis and inappropriate treatments and medications—even death. A Medic Alert (www.medicalert.org) bracelet or necklace worn by an individual indicates vital medical facts and provides a 24-hour-a-day toll free telephone number to access additional medical facts, plus physician and family contacts.

HEY ARE HIGH ACHIEVERS

KALEIDOSCOPE Television (www.ktv-i.com) and Schering Laboratories have launched a television series entitled Achievers, aimed at educating providers, caregivers, and patients about the impact of allergy and asthma. Each 30-minute show focuses on true-to-life portraits of people who have overcome the challenges of allergies and asthma. With

over 15 million Americans who suffer from asthma and 44 million who suffer from allergic rhinitis, the timing for Achievers, remarks Richard W. Zahn, president of Schering Laboratories, has never been better.

THEY'VE BEEN WORKING ON THE WORKFORCE

The focus is on physicians—at least for the New Jersey Commission on the Physician Workforce, chaired by Princeton urologist Robert L. Pickens, MD. With some of the top major players in the health care field, the Commission will create a framework for a realistic approach to physician workforce issues. The Commission will distribute a white paper outlining its approach. MSNJ members who want to stay in tune with this grant-funded initiative convened by MSNJ can get updates on MSNJ's web site (www.msnj.org), under the "Membership Matters" section. For more information, call MSNJ, 609.896.1766, extension 282.

@ M S N J

BOOKMARKS

pw1.netcom.com/~seajr/medical_spanish.html

Intended as a guide for health care workers, Medical Spanish site provides a guide to common Spanish words and phrases, with English counterparts, useful in medical settings.

www.peoplelink.com

The first online communications service designed for people who want to network with other people.

www2.umdj.edu/radweb/intr_cme.html
RadWeb, developed by UMDNJ-Robert Wood Johnson Medical School Department of Radiology, offers a series of CME case studies for CME credit.

www.thefreesite.com

Get lots of free stuff at The Free Site, like digital postcards, music, product samples, and computer fonts, graphics, and software.

plague.law.umkc.edu/

Access the text, *Law and the Physician: A Practical Guide*, online at The Medical and Public Health Law Site. It provides an overview of the relationships between physicians and lawyers, patients and their families, and medical personnel.



HEALTH LAW PRACTICE

*representing healthcare providers,
including physicians, physician groups, other
clinical professionals, academic medical
centers, multihospital systems, independent
acute care and specialty care hospitals,
ambulatory care centers, and nursing and
assisted living facilities*

For more information or a copy of our
New Jersey Health Law Advisory,
please contact
Alma L. Saravia
51 Haddonfield Road
Cherry Hill, NJ 08002 • (609) 488-7300

DUANE, MORRIS & HECKSCHER LLP

A PENNSYLVANIA LIMITED LIABILITY PARTNERSHIP

Cherry Hill and Newark, New Jersey
with additional offices in
Pennsylvania • New York • Washington, D.C.
Delaware • Florida • Texas

Lowest Premiums for Quality Malpractice Insurance

The Joseph A. Britton Agency can help make it happen! If you are a preferred risk¹, you can qualify for preferred rates². Compare these annual premiums at occurrence limits of \$1,000,000/\$3,000,000:

• Anesthesiologists	\$ 8,572
• General Surgeons	\$18,453
• Internists	\$ 5,331
• Ob-Gyns	\$39,000
• Radiologists	\$ 5,331
• Plastic Surgeons	\$23,350
• Psychiatrists w/ect	\$ 2,937
• Urologists	\$11,993

With more than 25 years of experience, the Britton Agency has proven exceptional in packaging malpractice insurance. Our professional staff and size assure you the benefits of specialized, personal service while offering you insurance at the lowest cost.

Call for a free consultation. Start saving tomorrow.



Joseph A. Britton Agency, Inc.

Healthcare & Professional Liability Insurance
855 Mountain Avenue, Mountainside, NJ 07092
(908)654-6464 • Fax: (908)654-1422 • 1(800)462-3401

¹Underwriting approval required.

²May need groups of 3 or more depending on specialty.

Medi-Bill Associates Offers Advance Funding

Medi-Bill Associates, Inc., a medical billing organization located in New York, offers an innovative Advance Funding program that helps physicians with their billing and cash management needs.

Answering these questions can help you decide if this program is right for you:

- Would you like to be paid on Thursday, for assigned patients seen on Monday?
- Are complicated billing codes preventing you from maximizing payment on assigned claims?
- Are you unable to devote the time necessary to follow-up on submitted claims?
- Are your accounts receivable out over 90 days?

If you answered yes to any of the above questions, Call

Medi-Bill Associates, Inc.

The **only** medical billing organization that pays physicians on their assigned claims **within 72 hours**

Don't Just Bill . . . Medi-Bill!



Medi-Bill Associates, Inc.

Advance Funding/Electronic Billing

Sales: 1-800-546-2414/Operations: 800-386-3771

The practice of medicine today

R. Gregory Sachs, MD

The following are excerpts from the presidential inaugural address presented by R. Gregory Sachs, MD, upon his inauguration as MSNJ president. For a complete copy of his address, please contact MSNJ executive offices or access it at www.msnj.org.

Like all of you, I love the practice of medicine. I was fortunate enough to enter medicine and choose the field of cardiology in the 1960s. Truly, the last 30 years have witnessed a golden era, not just in my own field of cardiology but for most of medicine. Unquestionably, it has been the most intellectually rewarding and personally satisfying time to have been a physician.

Will the best and brightest youths of the next decade pursue the practice of medicine when they learn what HCFA and managed care have in store for our profession? I fear we would all agree that few of the best and brightest youths now would choose medicine as a career. Especially when a two-year graduate with a computer science degree, a

two-year MBA degree, or a three-year law degree will be gobbled up by Big Business with starting salaries of \$100,000, Wall Street-size bonuses, and stock options. All this comes with none of the personal, legal, and financial risks and stresses inherent in the life of a physician. What will it take to restore the allure of the medical profession? I suggest it will require those of us currently in practice to rapidly and aggressively pursue a series of professional, business, and legislative strategies.

PROFESSIONAL STRATEGIES

Physicians of all specialties must recognize that Medicare and Medicaid are federal programs and that the only umbrella organization that can bargain forcibly with the federal government (HCFA) is the AMA. Therefore, all physicians must immediately join the AMA and guide its policy so it can credibly claim to HCFA, Congress, and the president that it represents virtually all practicing physicians.

Physicians of all specialties also must recognize that insurance companies (including managed care) are regulated not by the federal government, but rather by the state government. Therefore, the only umbrella organization that can bargain forcibly with the state government in New Jersey is the Medical

Society of New Jersey (MSNJ). Therefore, all New Jersey physicians must join both MSNJ and JEMPAC, and also vote to send a significant portion of their hospital medical staff dues annually to MedAC (our own state political action committee). Thirty-five New Jersey hospital medical staffs already do so—my own medical staff at Overlook Hospital sends \$25,000 yearly to MedAC. If every medical staff did so, MedAC and JEMPAC would be the most powerful political lobby in New Jersey.

BUSINESS STRATEGIES

Physicians must rapidly organize into medical business entities capable of legally approved "collective bargaining" with managed care.

These medical business entities then must obtain experienced actuarial advice so as to pursue and profit from so-called professional risk contracts.

These medical business entities will need to achieve efficient utilization of hospital beds so that they can accept and profit from so-called global risk contracts.

Remember that 40 percent of the insurance premium dollar pays for hospital care. Therefore, if hospital bed utilization can be cut in half, this represents a huge profit that either goes directly to the pocket of

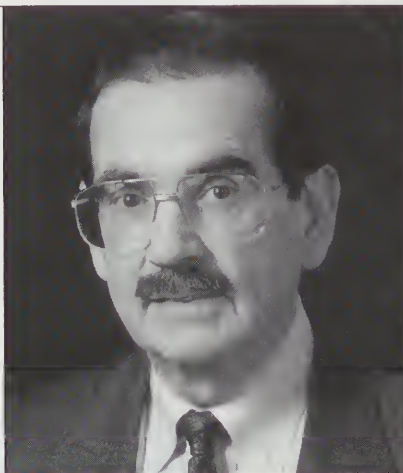
the managed care organization or can go to the medical business entity, which took a global risk contract.

PROMPT PAYMENT STRATEGIES

The first step already has been taken with the passage of the HMO regulations by the New Jersey Department of Health and Senior Services (DHSS) and the Health Care Quality Act by the New Jersey Legislature in 1997. These are the strongest HMO laws and regulations in the United States and represent great political success on the part of MSNJ in 1996-1997. However, these laws and regulations are largely for the protection of our patients and only indirectly and partially benefit physicians.

The second step was when MSNJ persuaded DHSS regulators to require HMOs to pay 10 percent interest on any clean claims not paid within 60 days. Now the challenge is to be certain that, if the HMOs fail to follow through on this commitment, they then will be substantially fined and publicly embarrassed in the press.

The third step is for MSNJ to convince DHSS and the New Jersey Department of Banking and Insurance to require that all contested claims be professionally reviewed at the insurance company by an independent auditor, i.e. a big accounting firm. This auditor should have



R. Gregory Sachs, MD

the state delegated power to require immediate partial or total payment with later reconciliation if the claim cannot be adequately substantiated or is accidentally overpaid.

ANTI-TRUST REFORM STRATEGY

On the federal level, the AMA must seek to cancel the McCarren-Ferguson Act of 1938, which gave federal anti-trust exemption to the insurance companies and to the managed care organizations.

The AMA and MSNJ must simultaneously push for "Teddy Roosevelt-like trust busters" at the state and federal level who will prevent or break up market dominating monopolies.

The AMA should push for a level playing field with legislative liberalization of collective bargaining rights for independent physicians.

E&M STRATEGY

The AMA should absolutely reject HCFA's recently rigid E&M

documentation guidelines. A simple signature from the patient confirming that the described service was provided should be sufficient. This is how government-sponsored medicine monitors office charges in other advanced countries such as France, Germany, and Japan.

MEDICARE PART B STRATEGIES

The AMA must push Congress to increase the size of the Medicare Part B pie by a series of budget neutral mechanisms.

Congress should create a sliding scale means test for Medicare Part B and require an increased financial contribution and/or permit increased balance billing for those seniors with high-level incomes or high-level assets.

Congress must permit private contracting on a case-by-case basis between physicians and those seniors with Medicare Part B who have high-level incomes or high level assets.

CONCLUSION

My fellow physicians, it is critical at the time for all physicians and all medical/surgical specialties to unite under the banner of MSNJ and the AMA to undo this bondage for both our good and for the good of all our patients. I feel confident that the profession of medicine will regain its lofty and legitimate position as the most respected of all professions.

We know that practicing medicine is your primary concern.

The professionals at Healthcare Management Partners will take away the time-consuming administration and pressures of billing, collections, follow-up, office management, and system maintenance, so you can concentrate on doing what you do best - practicing medicine.

Contact Rosalie Fox or Robert Rahl at 609-734-0443 to find out more.

**Practice Assessments • Billing & Collection •
MIS Systems • Group Practice Formation •
Practice Management • Income Distribution**

**Endorsed Computerized Billing,
Accounts Receivable and
Information Management Company of the
Medical Society of New Jersey**



HEALTHCARE MANAGEMENT PARTNERS

PARTNERS IN PROFIT

200 Canal Pointe Boulevard • Princeton, NJ 08540-5998
609-734-0443 • FAX 609-243-9799

A Division of Health Information Consulting Services, Inc.

INCREASING NUMBERS OF WOMEN ARE PARTICIPATING IN ATHLETIC PROGRAMS. BUT AT WHAT RISK? WITH SO MUCH EMPHASIS PLACED ON WEIGHT AND ITS EFFECT ON PERFORMANCE, THEY ARE IN DANGER OF DEVELOPING A SERIOUS MEDICAL CONDITION KNOWN AS THE FEMALE ATHLETE TRIAD. IT STARTS WITH EATING DISORDERS AND LEADS TO AMENORRHEA AND OSTEOPOROSIS.

Weighing the cost of **Athletic** PERFORMANCE

Karen Guozzo

Weighing in can be a tortuous experience for athletes, especially women athletes. Everyday they wage war against their weight and engage in an ongoing battle with the number on the scale. For some athletes, losing weight is an obsession. Normal fluctuations are viewed as fat gains, and drastic measures are taken to lose the added weight. MSNJ member Richard Levandowski, MD, a physician for the United States track and field team, states, "Admittedly, there is some advantage, in running sports in particular, to be a bit lighter. But there's a fine line between what's healthy and

what's abnormal." And, unfortunately, the consequence of the athlete's behavior usually is more than just unhealthy; it can be fatal.

Sports medicine professionals worry about the long-term effects of the female athlete triad, a condition initiated by disordered eating behavior and culminating in amenorrhea and osteoporosis. According to Christine Haycock, MD, a member of the MSNJ Committee on the Medical Aspects of Sports, the triad is a serious medical state that can have severe physical manifestations. And Levandowski has witnessed the damaging effects of the



Rider University volleyball player Audrey Lewis is training for the new season.

On the cover: Rider University volleyball player Kim Robins works out every day in preparation for games. © Conrad Gloos

triad during his appointment as team physician at Princeton University. He recounts, "There was a young woman who was merely working out on the weight machine and she broke her upper arm just below the shoulder. Her bone just snapped. It was because she had an eating disorder."

Although virtually any female athlete is susceptible to the conditions of the triad, those women and girls who are involved in sports that stress appearance and low body weight are especially vulnerable, and the risk is even greater for those who participate at the elite or highly competitive levels. The disorders most commonly afflict women gymnasts, figure skaters, ballet dancers, and distance runners, but the triad is known to affect athletes of other sports, such as basketball and volleyball. Rider University women's volleyball coach Nancy Roberts reports that she has worked with about seven or eight female basketball and volleyball players who suffer from eating disorders.

EATING DISORDERS

Eating disorders result in diminished athletic performance and are manifest, according to Roberts, by a "lack of strength in practice, unusual fatigue, lack of focus, and a loss of game face. Instead of presenting herself with confidence, the athlete who is suffering from an eating disorder looks fearful when she gets on the court." Much worse, the athlete also has an increased risk of developing serious medical problems including cardiovascular, endocrine, and gastrointestinal system disturbances (Table 1). Haycock notes, "Disordered eating behavior can lead to very severe medical conditions, such as pancreatitis and even a ruptured esophagus."

Psychologists think that disordered eating behavior may be a

reaction to the rigors of sports training. They say that the young athlete is acting out against her feeling a lack of control over her environment or that she is feeling repressed or isolated by a highly structured lifestyle. Eating disorders also arise from the pressure to succeed at a sport. Even though there is no direct evidence to support the claim, athletes who are susceptible to disordered eating behavior equate weight loss with performance gains and believe, in terms of their weight, that less is more. Roberts states that "sometimes they think they'll be able to perform better when, in essence, they become weaker."

Societal pressure is another contributing factor in influencing the athlete adversely. Haycock believes that too much emphasis is placed on physical appearance. She feels that other than the athlete's need to look good out on the court, "there is no physical reason for a female basketball player to weigh 159 pounds. If she is, say, 6'3" she should be able to carry 180 pounds and still be able to move." Haycock, an ex-basketball player who stood 5'7½" and weighed 165 pounds, reports that the weight "didn't mean I couldn't move. In fact, I was quite strong in terms of upper body strength and could heave the ball."

Due to the stigma attached to disordered eating behavior and its inherent secretive nature, diagnosis or confirmation of the condition is difficult, and prevalence data are limited. Studies indicate that eating disorders affect from 15 to 62 percent of female athletes, depending on the sport. There are several anorexia and bulimia common signs and symptoms of the eating disorders (Table 2), and observation of these characteristics is a red flag when evaluating the female athlete. However, as both Levandowski and Haycock attest, it can be difficult for the physician to spot disordered eating behavior. Although Levandowski routinely looks for symptoms during height and weight checks, he cautions that diagnosis of bulimia is difficult

Common characteristics of female athlete triad patients

- Perfectionist personality;
- high expectations for self
- Competitive athlete
- Self-critical behavior
- Low self-esteem
- Depressive symptoms
- Achieving/maintaining low body weight and lean physique
- Stress fracture without significant change in training
- Multiple or recurrent stress fractures
- Young age

because the patient can have what seems to be a normal body type. As Haycock notes, "The biggest problem is recognition, and that's not always easy. The girls are very secretive about their behavior." Levandowski recommends using a series of open-ended leading questions to confirm a suspicion of disordered eating behavior.

AMENORRHEA

Until recently, amenorrhea was accepted as a normal consequence of physical training, and those females who participated in sports often expected irregular menstrual cycles. Levandowski points out there was a time when some coaches felt that if a female athlete was still getting her period she wasn't training hard enough. However, it is now known that amenorrhea is a symptom of a potentially serious health problem. Haycock states that "any athlete who has gone longer than three to four months without a period should have a thorough check up," which should include, but not be limited to, a blood count, a urinalysis, and a determination of iron, thyroxine, thyrotropin, and estradiol levels. Levandowski agrees, stating that "a women athlete should be having, as a general rule of thumb, at least six periods a year. If not, we should start thinking about problems relating to hypoeestrogen."

Although the cessation of normal menstrual cycles commonly is linked with physical training and sports participation, the etiology of exercise-associated amenorrhea is not known completely but is thought to be hypothalamic in origin. A reduction in the frequency of luteinizing hormone (LH) pulses from the pituitary gland causes amenor-

Table 1. Complications of anorexia nervosa and bulimia.

Loss of muscle strength	Loss of endurance
Decreased oxygen utilization	Decreased aerobic power
Decreased speed	Loss of coordination
Impaired judgment	Reduced blood volume
Less blood flow to the kidneys	Loss of all muscle glycogen
Reduced heart function	Increased heart rate
Electrolyte loss	Inability to regulate body temperature

rhea. This reduction in LH pulse frequency is thought to be caused by a decrease in the frequency of gonadotropin-releasing hormone (GnRH) pulses, secreted by the hypothalamus. Current research is focusing on the regulation of GnRH-secreting cells, and two theories are emerging.

One theory attributes the disruption in GnRH pulse frequency to exercise stress and the other theory to energy availability.

OSTEOPOROSIS

The third disorder of the female athlete triad, osteoporosis, is characterized by low bone mass and microarchitectural deterioration of bone tissue, leading to increased skeletal fragility and a heightened risk of fracture. Osteoporosis results from a loss of existing bone material, from the failure to lay down bone during critical developmental periods, or from a combination of both. Researchers have linked osteoporosis to decreased ovarian hormone production and inadequate estrogen production as a result of hypothalamic amenorrhea. As Levandowski notes, a woman needs circulating estrogen to help build bones. Haycock states, "Exercise, in general, is a good stimulant for bone formation, and bone mass increases when you stress it. But if body chemistries are off, this can't happen."

Evidence suggests that 60 to 70 percent of a woman's peak bone mass is acquired during the adolescent growth spurt, which usually occurs between the ages of 15 and 19 years. But, as Haycock says, at this age "the athlete will not get alarmed over premature bone density loss. It's something that is off in the distant future." Research shows, however, that the adolescent athlete who is susceptible to developing disordered eating behavior and amenorrhea also is at risk of developing, at a young age,

a serious disorder symptomatic of old bones. Barbara Drinkwater, a noted physiologist and a pioneer in osteoporosis research, found, when examining amenorrheic athletes, many instances of young females who had bones comparable to those of 50- to 60-year old women. In one case the patient, at age 19 years, showed an apparently normal spine, but by age 23 she had suffered three vertebral wedge fractures. Drinkwater also reported that approximately 50 percent of the amenorrheic athletes who were studied had bone densities below the level at which hormone replacement therapy for menopausal women is recommended by The National Osteoporosis Foundation.

Both Levandowski and Haycock point to repetitive stress fractures as a primary indicator of premature osteoporosis. Levandowski, team physician at various New Jersey schools including The Hun School, Pennington School, and the College of New Jersey, says, "We become concerned when we see recurrent injuries that just don't seem to get better. Most young athletes get better so very quickly that when we see a woman who has stress fractures we think about eating disorders and hypoeestrogen."

It appears, for the most part, the damage from premature osteoporosis is irreversible. Although some limited gains in bone mass density have been seen following the resumption of normal menstrual cycles and estrogen replacement, neither was seen to have a sustained impact on bone accretion.

TREATMENT OF THE TRIAD

The preferred method of treating the female athlete triad patient is to encourage changes in certain behavior patterns that will allow or lead to a resumption of normal menses. A multidisciplinary approach is viewed as the most effective in achieving this goal. Haycock says, "It takes a team to treat the athlete. You need to have a family doctor, psychologist, and nutritionist involved."

In many instances the first step in treating a female who suffers from the effects of the triad is to help her admit that a problem exists. This can be difficult because most victims of an eating disorder deny the problem. Following this, counseling is recommended to aid the athlete in identifying behavioral patterns that led to the development of the eating disorder. At this point, coaches, in particular, as well as others associated with the athlete, can help by employing some simple strategies: de-emphasize the impact of lower weight on performance, stress the role of good nutrition and weight maintenance to enhance performance, and set a realistic target weight and a reasonable rate of weight loss, if required. Coach Roberts also recommends that the athlete continues participating in her sport. She feels that the psychological damage that could be done by removing her from the sport could be more harmful than the potential physical damage. "That's the most important

thing," attests Roberts, "not taking her out of her norm, not separating her from what she loves to do, because then she loses her self concept even more."

Nutritionally, the athlete needs to adjust her diet to allow for sufficient caloric intake to meet both routine daily needs as well as sports requirements. Intake of 1,500

Table 2. Common signs and symptoms of anorexia nervosa and bulimia.

Anorexia	Bulimia
Amenorrhea	Swollen parotid glands
Fat and muscle loss	Chest pain
Dry hair and skin	Fatigue
Cold, discolored hands and feet	Abdominal pain
Decreased body temperature	Erosion of tooth enamel
Lanugo, particularly on trunk	Face and extremity edema
Lightheadedness	Diarrhea or constipation
Decreased ability to concentrate	Menstrual irregularities
Bradycardia	Knuckle scars
	Bloodshot eyes

mg/day of calcium and 400 to 800 IU/day of vitamin D is recommended, and a restriction in exercise is advised to guard against a sustained energy drain. Hormone replacement as a form of treatment remains questionable; no data are available on correct dosages or preferred means of administration. The only available source of this information comes from the data on postmenopausal women, and its direct applicability to young athletes is questionable.



Rider University volleyball player Audrey Lewis works out in preparation of an upcoming game.

Efforts are underway to inform and to educate the athletic community about the dangers of the female athlete triad. WomenSport International (an international organization of sports-related professionals whose expertise derives from the fields of sports medicine, nutrition, coaching, health and fitness, and administration)

convened a panel of experts to study relevant health issues affecting women athletes. In 1997, the American College of Sports Medicine (ACSM) issued a position statement that cautioned that the triad could result in medical and psychological morbidity and mortality. Additionally, the ACSM's Ad Hoc Task Force on Women's Issues in Sports Medicine developed a "call to action" plan to address strategies for future prevention and treatment of the female athlete triad. WomenSport International and the Medical Commission of the International Olympic Committee established a joint task force to examine ways to prevent the triad. The goals of the task force are: to educate the athletic community about the seriousness of the problem and the related health risks of the triad; to establish standards of conduct for coaches that prohibit the type of behavior that encourages disordered eating; to examine the rules governing each sport to see if changes might discourage the type of behavior that leads to the female athlete triad;

and to promote the positive aspects of sports and the physical, social, and psychological benefits of regular participation in physical activity.

Officials at Rider University are addressing the issue head on. Athletic director Curt Blake says, "In athletics there's always that fine line in trying to attain optimal performance, and weight is a factor. But there's an appropriate way to fine tune the human body, and there's an

inappropriate way. That's where I've always felt the issue of eating disorders comes in. It's one that starts with the idea of trying to streamline one's self, but it evolves, or can evolve, quite quickly into a significant medical problem." Programs have been implemented at Rider to tackle the problem. Earlier this year, Rider acted as a screening site in the National Eating Disorders Screening Program (NEDSP). Attendees learned about eating disorders, took written screening tests, reviewed the results with clinicians, and received referrals, when necessary, for followup evaluations.

"Another piece is the aspect of training techniques. It's something that we've been working on and have become much more involved with over the last five years," asserts Blake. Blake feels that the athletes are training more appropriately. He says now they are gaining strength the right way and attributes this not only to the improvement in fitness center equipment but also to the growth in the staff's knowledge about the effects of sports training and eating disorders. For example, Rider University trainer Lisa Treadway-Kurtz reports that she and an assistant have enrolled in courses to learn more about eating disorders and the triad, issues that were just skimmed over in their undergraduate and graduate education. Treadway-Kurtz also notes that the National Collegiate Athletic Association has become very proactive in providing educational materials on the triad, and she expects the National Athletic Trainers Association to address the issues of eating disorders and the triad at future national conventions.

Wouldn't **you** rather

practice medicine

than **wrestle**

alligators?

Whatever challenges you face or opportunities you contemplate, the right legal counsel can spell the difference between a tangle of complications and a successful outcome.

Tamborlane & Printz focuses decades of experience and insight on your needs regarding managed care contracts, state and federal

We
thought
so.

compliance requirements, countless other issues.

Call us and speak with attorneys called upon for guidance by America's most prestigious medical associations and health law publications. We'll help you maximize the rewards and minimize the risks associated with providing quality health care.



Tamborlane & Printz, P.C.

Counselors at Law

New Jersey: 908-789-7977 1044 Route 22 West, Mountainside, NJ 07092

Florida: 305-296-2700 1800 Atlantic Boulevard, Suite 208A, Key West, FL 33040

Email: law@tamborlane.com

LIVING LONGER

LONGEVITY HAS INCREASED AT A REMARKABLE RATE IN THE 20TH CENTURY, REPRESENTING ONE OF THE MOST SIGNIFICANT BEHAVIORAL CHANGES IN ALL OF HUMAN HISTORY. THROUGHOUT MUCH OF HUMAN CIVILIZATION, LIFE EXPECTANCY RANGED BETWEEN 20 AND 30 YEARS. AFTER 1875, WITH MAJOR ADVANCES IN PUBLIC HEALTH AND MEDICAL CARE, LONGEVITY OF AMERICANS HAS INCREASED WITHOUT INTERRUPTION.

Bill Berlin, PhD

The bell tolls for all of us, but it tolls more frequently for some people, in some places, than for others. Consider these facts: In Essex County, the average life expectancy for an African-American male is 60.1 years; just ten miles away in Bergen County women of Asian background have a life expectancy of 97.7 years. An Oglala Sioux man on the Pine Ridge Reservation in South Dakota has a life expectancy of 56.5 years, the lowest in the nation; women from Stearns County, Minnesota, average 83.5 years, the highest in the United States.

How can we account for these sharp differences in longevity? Why do women typically live longer than men? Why do certain population groups have distinctly higher life expectancies than

the rest of us? What factors contribute to a long and healthy life?

As the baby boomers evolve into an elder explosion, these and other questions are intriguing geriatricians, gerontologists, genetic researchers, and specialists in such new fields as biodemography and biogerontology. The astounding growth of the "older old" population of 85 and above has fueled speculation that we may be entering a new era in which medical research and practice will enable people to live longer and healthier lives. One thing is clear, though, longevity has increased at a remarkable rate in the 20th century, representing one of most significant behavioral changes in all of human history. Throughout much of human civilization, life expectancy ranged between 20 and 30 years. By the middle of the 16th century, longevity had risen into the 30s, where it stayed until the early 19th century. After 1875, with major advances in public health and medical care, longevity has increased almost without interruption.

A century ago, the average life expectancy in Western industrialized nations lingered in the low 40s, anchored by high rates of early

childhood mortality. Since 1900, people in industrialized nations have gained 25 years in life expectancy, doubling the increase in all prior human history. In the United States, life expectancy has grown from 47 at the turn-of-the-century to 76 in 1996, with much of the increase occurring since 1950.

Tucked within these numbers are some striking trends. For one thing, women almost everywhere tend to live longer than men. In the United States, a female at birth can be expected to live 79 years, while a man can anticipate 72 years. The gender gap is even greater in other nations, and has widened throughout the 20th century (although in the United States it has narrowed slightly during the last decade). And even though historical data are sketchy, women probably lived longer than men in the past, despite high rates of death during childbirth.

MSNJ member Morris Soled, MD, understands the older population's medical and health care needs.



The second trend, however, is even more surprising, and has significant implications for human longevity. Since 1950 there has been a marked decline in older age mortality, with concomitant increases in elderly survival in such nations as the United States, Japan, England, France, and Iceland. For the older old population, death rates have increased at a slowing rate and may actually plateau as people get into their 90s. One study that looked at mortality rates among eight million people found that death rates flattened after the age of 97. In 1940, only 3,700 people reached the age of 100; today, roughly 61,000 people have attained the century mark.

In New Jersey, the 85 and over population is projected to increase by 89 percent between 1994 and 2010, making it the fastest-growing age group during this period. However, despite widespread concerns about the economic implications of an aging society, many of the older old probably will age like good wine. Disability rates have declined among the 65 and older group since the late 1980s, as have rates of hypertension, dementia, and arteriosclerosis. And researchers have discovered that many individuals who survive into their 90s and beyond experience better health than people 20 years their junior.

Thomas Perls, MD, a Harvard Medical School geriatrician and researcher, is one of the nation's leading experts on the oldest of the old. Before starting his practice, Perls anticipated that people over the age of 95 would be his most debilitated patients. "Yet when I became a fellow in geriatrics," Perls writes, "I was surprised to find that the oldest old were often the most healthy and agile of the senior people under my care."

Perls' work with people who reached the century mark uncovered an interesting pattern. Many centenarians reported that during their 90s they worked, were sexually active, and enjoyed outdoor and cultural activities. Most indicated that they had few health problems and little, if any, physical deterioration. Moreover, those who lived to a ripe old age seemed to die faster, with relatively brief periods of infirmity before death. A study by James Lubitz of the Health Care Financing Administration found that for people who die at age 70, the average medical expenditure for the last two years of life was \$22,600, compared to \$8,300 for people who died after age 100.

**MEN WHO LIVE INTO
THEIR LATE 90s HAVE
STRONGER INTELLECTUAL
FACULTIES THAN MEN A
DECADE YOUNGER.**

How can we account for the exceptional resiliency and staying power of the oldest old? Perls suggests a "selective survival" hypothesis, basically a geriatric variation on an old Darwinian theme. In this view, people who endure into their late 80s and 90s without the disorders that often accompany aging are more likely to continue surviving without serious infirmities and thus outlive their peers. For example, men that live into their late 90s usually have stronger intellectual faculties than men a decade younger. Men who are vulnerable to dementia and Alzheimer's disease are apt to die in their 80s.

Can the "selective survival" approach explain why women, the allegedly "weaker sex," outlive males in almost every country and within every species? Perls speculates that longevity may be an evolutionary adaptation to the long period of nurturing required to raise chil-

dren. Menopause curtails the female's reproductive stage at the point of greatest risk, allowing women to continue nurturing as mothers and grandmothers.

Biological differences may account for gender variations in life expectancy. For one thing, women seem to have more efficient immune systems than men. Estrogen has a protective effect, raising the "good" HDL cholesterol, lowering the "bad" LDL, and serving as a powerful antioxidant against free radical scavengers that damage cells. Testosterone, on the other hand, tends to raise LDL and reduce HDL, especially as men age. Women usually have a slower metabolism than men, again restraining the free radical attack on cells, and possibly extending the cellular and organic life cycles.

Women also are more likely to suffer from chronic, non-fatal diseases than men, which may indirectly contribute to their longer life expectancy. Nagging, long-term illnesses may bring individuals more frequently into the doctor's office, where according to retired geriatrician Morris Soled, MD, "Many times I found a major problem early while I was treating a minor one."

Longevity seems to be a product of both nature and nurture:

- *Is it all in the genes?* Genetic research has made substantial

progress in unraveling the micro-mysteries of aging. Molecular biologists have discovered an enzyme called telomerase that appears to sustain cell life, and scientists are now searching for genes that regulate its production. Other researchers have identified "clock" genes that regulate aspects of aging. Longevity tends to run in families, as does vulnerability to certain diseases that can result in early death.

• *Nutrition and diet.* One clue to aging may be that people who live to be 100 years are rarely obese. A growing body of research has connected nutrition to good health and disease prevention and high fat intake to greater risk of cancer and cardiovascular disease. Yet to this point there is little evidence that historical improvements in diet are associated with a decline in mortality rates. Longevity, however, may be associated with eating less — under-nutrition, rather than malnutrition. The best advice seems to be to follow a balanced diet and not eat to excess. "The worst thing you can tell a 90- or 100-year-old person is not to eat," says Joshua Schor, MD, a geriatrician associated with Newark Beth Israel Medical Center and Daughters of Israel Geriatric Center. "The extra five or ten pounds of body weight can help

them survive infections and other health crises."

• *Exercise.* For many elderly people, physical decrepitude stems from physical disuse, and exercise can produce remarkable improvements in disease prevention and quality of life. A recent study that followed 16,000 healthy men and women in a Finland national registry of twins for almost two decades, found that six brisk half-hour walks per month cut the risk of death by 44 percent. Those who exercised just occasionally still were 30 percent less likely to die than their less active twins. Vigorous exercise is associated with reduced rates of heart and lung diseases, and lower mortality rates. Research has shown that even in the frail elderly, moderate aerobic exercise and working with weights can strengthen bones, reduce body fat, and prevent falls.

• *Friendship and optimism.* Lisa Berkman, PhD, an associate profes-

sor of epidemiology at Yale University School of Medicine, has shown that emotional support and social connectedness are significant components of health and healing. In one study of 194 people hospitalized for myocardial infarction, those who reported having no source of emotional support died at twice the rate of people who had two or more people with whom they could talk. Managing stress, taking on challenges, and approaching life with a sense of optimism are important, if intangible, factors in longevity. Various studies have established a connection between depression, disease recurrence, and a higher risk of mortality. Laughter and mental stimulation also have been shown to stimulate the immune system.

There is much that we still are learning in our quest for the Holy Grail of longevity, but clear trends have emerged. We know that life expectancy strongly correlates with wealth and education, and that progress in public health seems to play a more profound role than advances in medical care. Medical breakthroughs, such as the discovery of antibiotics and penicillin, have kept people alive longer. But staying healthy in mind and body and keeping active through social and community ties, may be the best routes to a long, fulfilling life.

**MODERATE AEROBIC
EXERCISE AND WORKING
WITH WEIGHTS CAN
STRENGTHEN BONES,
REDUCE BODY FAT, AND
PREVENT FALLS.**

Our doctors aren't just great. They're the best.



Hudson County's best doctors practice at St. Mary Hospital of Hoboken and St. Francis Hospital of Jersey City. With nearly 600 skilled, caring professionals, our medical staff includes a growing number of leading specialists who are nationally-recognized experts in fields like perinatology, internal medicine and psychiatry.

So when you're looking for a doctor, choose the best.
Call (201) 418-2020.

**ST. FRANCIS
HOSPITAL**
of Jersey City

**ST. MARY
HOSPITAL**
of Hoboken

The best doctors and nurses. Right in your neighborhood.™

Medical Society of New Jersey

Long Term Care Insurance Program

Ensuring a Secure Future by Preserving Assets

As medical professionals, you know first hand the devastating effects that extended long term care can have on a person's hard earned assets. The cost of nursing home stays can range from \$3,000-\$5,000 per month. The Medical Society of New Jersey endorses The Travelers and CNA Insurance Companies' policies to help you guard against unforeseen tragedies. Through a special arrangement with The Travelers and CNA Insurance Companies, members, spouses, parents and in-laws are eligible for a premium reduction.

IMPORTANT FEATURES OF THE MSNJ ENDORSED LONG TERM CARE INSURANCE PROGRAM

- ◆ Available Ages 45-84
- ◆ Specialty Plans Available Ages 80-100
- ◆ Benefits up to \$250/day
- ◆ No prior hospitalization required
- ◆ Several waiting periods
- ◆ Alzheimer's, senility covered
- ◆ Lifetime benefits available
- ◆ Guaranteed renewable for life
- ◆ Coverage for custodial, skilled and intermediate care as well as adult day care
- ◆ Available to your spouse, parents and in-laws
- ◆ Waiver of premium benefit
- ◆ Inflation protection available

DISCOUNT FOR MEMBERS OF MSNJ, SPOUSES, PARENTS AND IN-LAWS

For more information, please call

DONALD F. SMITH & ASSOCIATES

A division of THE COPELAND COMPANIES[®]

Two Tower Center, P.O. Box 1063
East Brunswick, New Jersey 08816-1063

(888) 297-7225

Copeland Associates, Inc.

Medical Society
MSNJ

POST-TRAUMATIC STRESS DISORDER HEALING THE HIDDEN TRAUMAS

POST-TRAUMATIC STRESS DISORDER OCCURS IN 5 PERCENT OF MEN AND IN 10 PERCENT OF WOMEN. CENTRAL TO THIS DISORDER IS THE OCCURRENCE OF A TRAUMATIC EVENT OR STRESSOR, OUTSIDE THE RANGE OF USUAL, NORMAL EXPERIENCE. IS THE MEDICAL PROFESSION TAKING NOTICE?

Sila Smith Noonan

It was initially known as post-Vietnam stress disorder. Then post-traumatic stress disorder (PTSD) appeared in the American Psychiatric Association's

Diagnostic and Statistical Manual of Mental Disorders in 1980; the diagnostic criteria was expanded in 1987 and again in 1994. "If the formal criteria were used, it's more likely that a person

involved in an automobile accident after 1994 would be diagnosed with PTSD than an accident victim in 1980," says Daniel P. Greenfield, MD, MPH, MS, a Millburn clinical



Aerial view of the New Jersey Vietnam Veterans Memorial.

and forensic psychiatrist and MSNJ member. According to the 1996 national comorbidity study, PTSD occurs in 5 percent of men and 10 percent of women.

Greenfield, who is familiar with court systems and litigation, believes the broadened criteria are having a "tremendous forensic impact" among patients who stand to gain financially by psychological elaboration of an injury.

This is not to say that drive-by shootings, carjackings, rapes, natural disasters, airplane crashes, automobile accidents, and even dog bites are not without psychological consequences for some people. In violent neighborhoods, for example, researchers have found an increasing number of children with PTSD, and there's concern that the disorder may be overlooked as the source of youths' bad behavior. "When that happens, these children may be wrongly placed in detention homes and not receive the treatment they need," says Kelly Reid, MD, an Absecon psychiatrist and MSNJ member.

Central to PTSD is the occurrence of a traumatic event, or stressor, outside the range of usual, normal experience, says Reid. And while

many people may be exposed to the same stressor, whether or not they will develop PTSD depends in part on their psychological makeup. "For example, if a person who is claustrophobic really is being suffocated, she may be more predisposed to PTSD than someone who is not claustrophobic," she says.

PTSD presents a variety of symptoms that last for more than one month: re-experiencing the event, sleep disorders, nightmares, irritability, an exaggerated startle response, hypervigilance, intrusive thoughts, avoidance of the stressor or things associated with the stressor, and other symptoms of anxiety and, over time, depression. A thorough patient history and eliminating organic causes of the symptoms can aid in diagnosing PTSD. "If the patient identifies the onset of symptoms with a trauma, that should raise a high index of suspicion with the primary care practitioner, who can then make the referral," says Greenfield.

Kelly Reid, MD, talks about treatment for PTSD patients.



Treatment for PTSD centers on therapy and, when appropriate, use of psychopharmacological agents. "The goal of insight-oriented therapy with PTSD patients is for them to understand the meaning of the traumatic event and the nature of their fears, and then resolve them," says Reid. "Any medication prescribed would correspond to specific symptoms, such as appropriate antidepressant agents for a patient experiencing depression." Because substance abuse often is secondary to PTSD, anxiolytic drugs are contraindicated in patients with such a history.

Eye-movement desensitization (EMD) is a new, controversial therapy being used with some PTSD patients. In this technique, the patient focuses on a traumatic memory and develops a statement of thought about the memory. Then, the patient visualizes the traumatic scene, rehearses the statement, and concentrates on physical sensations related to the trauma. Next, the patient visually tracks the therapist's finger, which moves left to right, back and forth, at about 10 to 12 inches in front of the patient's face at a designated speed.

"The idea is for the patient to develop a neutral, nonevocative association with the trauma," says Greenfield, who has referred PTSD patients to psychologists who conduct the therapy. "The question is not so much whether EMD works, but rather, how long it lasts."

Veterans with PTSD have the option of residential programs at Department of Veterans Affairs (VA) hospitals. While veterans and civilians may have similar PTSD symptoms, there are different elements to treatment, says Dr. Tom Hundersmarck, a psychologist and coordinator for PTSD patient programs at the VA New Jersey Health Care System in Lyons. "The traumatic events veterans were exposed to usually occurred many years ago, as compared to recent incidents affecting civilians," he says. "Some veterans have unique contributing health factors, such as Agent Orange or Desert Storm syndrome, and they simply may not feel comfortable sharing feelings with those who have not served in the military."

The PTSD Residential Rehabilitation Program at Lyons treats 200 veterans each year; with about 60 programs nationwide, it ranks in the top 10. In the 45-day program, veterans live with the people who are in their four-times-a-week group therapy. "The emotional investment becomes greater with an inpatient setting, and it demands a higher level of trust," says Hundersmarck. "Hopefully, the group provides the forum where, surrounded by their veteran peers, they let down their guard and share their experiences, their grief, and, tangible or not,



Visitors to the memorial observe a statue dedicated to the New Jersey armed forces.

their loss. Often, these veterans share pain they've been carrying around for decades."

Together with the program's staff, which includes physicians, psychologists, social workers, and rehabilitation technicians, the veterans develop strategies for dealing with their feelings, vocational problems, and other PTSD-related difficulties. As part of the program, the veterans visit the Vietnam and Korean war memorials in Washington, DC, which most often is an emotional and therapeutic trip, says Hundersmarck. There is no readmission to the Lyons program, but veterans

Visitors read the names of those killed during the Vietnam era.



who require further help are directed to after-care outpatient resources and other residential programs.

Critical incident stress (CIS) debriefings—counseling and informational sessions made available to witnesses or survivors of trauma—may be one way to derail PTSD, although only anecdotal evidence backs up this theory, says Greenfield. "Debriefings enable people to vent their emotions and concerns, let them know they are not alone with their feelings, and educate them about what might happen to them down the road."

CIS debriefings, introduced to the fire service in the early to mid-1980s, initially were greeted with suspicion. Today, most firefighters acknowledge that the debriefings have a valid role. Bill Peters, a Jersey City Fire Department battalion chief and apparatus supervisor, participated in a session four years ago. During a fire, a ladder fell on power lines, killing one firefighter, producing shock in another, and causing a third to lose fingers and toes. The fallen firefighter, who reported to the call while off duty, was one of Peters' men. "I was beating myself up inside for not replying to the call," he says. "It really bothered me, so I went to the debriefing and found it pretty valuable. We had a chance to talk about our feelings, and I put in my two cents worth and said I was sorry I wasn't there. Every firefighter thinks he's a macho man, but deep down, our inside voices tell us otherwise."

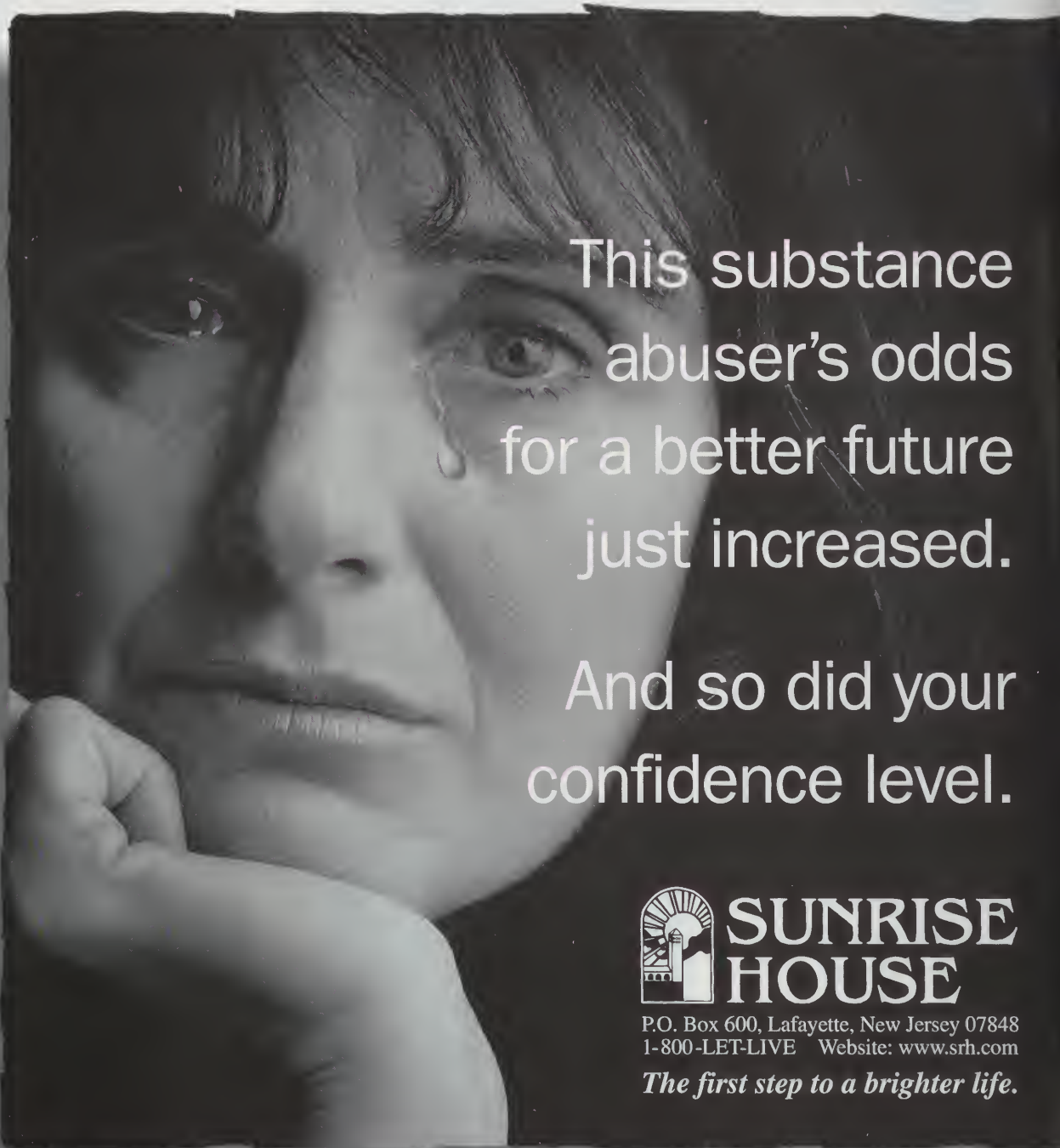
Whether it's an alcohol or drug problem, count on Sunrise House for expert help.

For 14 years, hundreds of tri-state area doctors have trusted us to offer their patients the most effective, caring treatment and a chance for a better life.

Set in the scenic hills of northwest New Jersey, we're a licensed, nonprofit specialty hospital with a nationally known commitment to quality—including Accreditation with Commendation by the JCAHO. Our comprehensive programs include inpatient and outpatient services, after-care and family support.

And our experienced staff of doctors and specialists works closely with referring physicians to ensure continuity of care at every stage of treatment.

Sunrise House. High-quality, affordable treatment you can trust. For information, call us at 1-800-LET-LIVE or (973)383-6300.



This substance
abuser's odds
for a better future
just increased.

And so did your
confidence level.



**SUNRISE
HOUSE**

P.O. Box 600, Lafayette, New Jersey 07848
1-800-LET-LIVE Website: www.srh.com

The first step to a brighter life.

Sunrise House is a preferred provider of most major insurance companies and HMOs.
We will process insurance benefits verification and precertification.

SYMPTOMATIC PULMONARY NODULE IN A YOUTH

CME Activity

A YOUNG MALE PRESENTS WITH HEMOPTYSIS AND A PULMONARY NODULE ON CHEST RADIOGRAPHY. THE PATHOLOGIC DIAGNOSIS WAS BRONCHOPULMONARY SEQUESTRATION. THE FINDINGS ARE DISCUSSED.

*David G. Landsnes, MD;
Randall L. Siegel, MD; Melissa
Chen, MD; John L. Nosher, MD*

A 19-year-old male presented with a one-month history of cough and expectoration of blood-tinged sputum that persisted despite antibiotic treatment. The patient had a six pack-year history of cigarette smoking. He denied shortness of breath, prior pneumonia, or tuberculosis. The patient's diagnostic evaluation included chest radiography followed by computed tomography (CT) and magnetic resonance imaging (MRI) of the chest. Following this diagnostic evaluation, the patient underwent video-assisted thoracoscopic surgery (VATS) resection of the right lower lobe.

RADIOLOGIC FINDINGS

Posteroanterior (PA) and lateral chest radiographs demonstrate a well-defined pulmonary nodule located in the right lower lobe



Figure 1. A posteroanterior chest radiograph demonstrates a well-defined round lesion just above the diaphragm in the right lower lung.

(Figure 1). Chest CT performed following the intravenous administration of contrast reveals a 2.0 x 2.5 x 2.0 cm ovoid nodule with clearly demarcated borders located in the right lower lobe. This nodule is associated with hyperaeration and oligemia of the adjacent lung parenchyma (Figure 2). Further evaluation with MRI demonstrates the mass in the right lower lobe to have low signal intensity on T1-weighted images that become brighter on T2-weighted images. No enhancement is demonstrated following intravenous gadolinium administration.

SURGICAL FINDINGS

At the time of VATS, sequestered lung tissue was identified in the right lower lobe. A large systemic artery was identified feeding the sequestered lung whose drainage was to the pulmonary vein. Resection of the right lower lobe sequestered lung then was performed during the VATS. The postoperative course was uneventful.

PATHOLOGIC FINDINGS

The surgical specimen consisted of the resected right lower lobe, which weighed 160 gm and contained a 3 cm cystic structure detected by palpation and seen on cut section (Figure 3). A systemic artery measuring 5 mm in diameter was seen entering the abnormal segment

of lung. On cut section, a 2.0 x 2.0 x 3.0 cm cyst with a bronchus-like protrusion was seen containing gray-green, thick mucus. The adjacent lung parenchyma was relatively soft and loose in texture and contained mucus-filled bronchioles distributed over an area of 5.0 x 5.0 x 5.0 cm. Light microscopy demonstrated the cyst to contain bronchial type respiratory epithelium (Figure 4). The surgical and gross pathologic findings of an abnormal segment of lung with systemic arterial supply and pulmonary venous drainage are consistent with intralobar bronchopulmonary sequestration.

DISCUSSION

Bronchopulmonary sequestration is a congenital malformation in which pulmonary tissue becomes detached from normally developing lung and receives a blood supply from a systemic artery. Two types of bronchopulmonary sequestrations are recognized: the intralobar type, with contiguous normal lung

parenchyma invested in a common visceral pleural envelope, and the extralobar type, which is enclosed in its own pleural envelope.

The lung develops as an outpouching of the primitive foregut at three weeks gestational age. Subsequent abnormal separation of a lung bud may result in continued branching and parenchymal growth that is independent of the rest of the developing lung. Numerous theories have been advanced to explain the development of sequestrations. Simplistically, if the supernumerary bud separates prior to development of the pleura, the resultant sequestration is intralobar, whereas separation after pleural development results in the extralobar type, with an independent pleural envelope developing to encase it.¹ Another theory is that intralobar sequestration is acquired, resulting from initial obstruction of a bronchiole leading to chronic inflammation and fibrosis, which interrupts the normal blood supply and leads to the secondary development of systemic collateral circulation.

Intralobar sequestration presents early in life with more than one-half discovered before 20 years of age. Symptoms typically consist of acute

Figure 2. Axial image from chest CT demonstrates an ovoid-shaped lesion in the right lower lobe surrounded by an area of relatively hyperaerated lung.



or repeated respiratory infections, but many cases are discovered as incidental findings at chest radiography. Intralobar sequestrations most often are located in lower lobes with two-thirds occurring on the left side. Intralobar sequestrations are supplied by systemic arteries arising from the distal thoracic aorta in 65 percent of cases, and the proximal abdominal aorta in 22 percent; these connections may be multiple. The remainder are supplied from the celiac axis, splenic artery, an intercostal artery, or the aortic arch. Venous drainage is by the pulmonary veins to the left atrium in 95 percent of cases and represents true systemic pulmonary vascular communication. In the remainder, drainage is to the right atrium, and rarely the inferior vena cava or azygous vein.² Considerable shunting may be present through this anomalous circuit. Communication with the airway usually is absent. When present, typically, the connections are abnormal and rudimentary; they may connect with extrapulmonary structures such as the gastrointestinal tract. Intralobar sequestration has been associated with other anomalies including diaphragmatic hernia, esophago-bronchial diverticular, and various skeletal, cardiac, renal, and cerebral abnormalities in about 14 percent of cases.³



Figure 3. Gross specimen of the resected right lower lobe, sectioned to demonstrate a mucous-filled cystic structure centrally.

In contrast, extralobar sequestration is surrounded by its own pleural envelope with 70 percent located between the lower lobe and the diaphragm. The remainder are located below the diaphragm or rarely in the mediastinum or pericardium. Extralobar sequestration is located in the left chest in 90 percent of cases, and may be associated with other congenital anomalies such as eventration or paralysis of the hemidiaphragm and/or congenital diaphragmatic hernias.⁴ Blood supply usually arises from the thoracic aorta and less commonly from the abdominal aorta or its branches. Although the venous drainage may be normal, it usually is to the right atrium, inferior vena cava, or to the azygos or hemiazygos system, and less commonly to the portal vein. Symptoms are rarely associated with extralobar

sequestration unless there is communication with the gastrointestinal tract or a rare hemodynamically significant left-to-right shunt (more likely in the intralobar type). Extralobar sequestration often is discovered during routine prenatal ultrasound as an echogenic or cystic thoracic mass.⁵⁻¹⁰

Radiographically, bronchopulmonary sequestration presents as a homogeneous, sharply-defined, lobulated mass usually abutting the diaphragm in the posterior portion of the lower lobe. The bronchovascular bundle of the normal lung may be identified draped around the sequestered lung.¹¹ Single or multiple cysts containing fluid or air/fluid levels may be seen in portions of intrapulmonary sequestered lung aerated through the pores of Kohn. When this area fails to clear with medical therapy, a malformation such as sequestration should be suspected. Calcification in pulmonary sequestration is rare. On chest CT, obstructive hyperaeration of the sequestered lung may be demonstrated as in this case, as well as mucoid impaction of the bronchus surrounded by hyperinflated lung. Contrast enhancement is irregular.

For symptomatic intralobar and extralobar sequestrations, complete surgical resection usually is necessary

in order to avoid recurrent infection.¹² A lobectomy is typically performed for treatment of an intralobar sequestration, while a "subsegmental" resection may be performed for an extralobar sequestration. Classically, preoperative angiography and venography were performed to delineate the sometimes unpredictable vascular anatomy. This also allows preoperative embolization, which has been performed to decrease bleeding prior to surgery.¹³

Computed tomography and MRI have been used for preoperative evaluation, occasionally demonstrating the vascular supply sufficiently to avoid more invasive studies.¹⁴⁻¹⁶

CME activity begins on page 51.

REFERENCES

1. Heithoff KB, Sane SM, Williams HJ: Bronchopulmonary foregut malformations. A unifying etiological concept. *AJR* 126:46-55, 1976.
2. Turk LN III, Lindskog GE: The importance of angiographic diagnosis in intralobar pulmonary sequestration. *J Thorac Cardiovasc Surg* 41:299-305, 1961.
3. Savic B, Birtel FJ, Tholen W: Lung sequestration: Report of seven

cases and review of 540 published cases. *Thorax* 34:96-101, 1979.

4. Ryan CA, et al: Congenital diaphragmatic hernia: Associated malformations—cystic adenomatoid malformation, extralobular sequestration, and laryngotracheoesophageal cleft: Two case reports. *J Ped Surg* 30:883-885, 1995.
5. Barret J, et al.: The prognostic factors in the prenatal diagnosis of the fetal echogenic lung. *Prenat Diag* 15:849-853, 1995.
6. Benya EC, Bulas DI, Selby DM, Rosenbaum KN: Cystic sonographic appearance of extralobar pulmonary sequestration. *Pediatr Radiol* 23:605-607, 1993.
7. King SJ, Pilling DW, Walkinshaw S: Fetal echogenic lung lesions: Prenatal ultrasound diagnosis and outcome. *Pediatr Radiol* 25:208-210, 1995.
8. Morin L, Crombleholme TM, D'Alton ME: Prenatal diagnosis and management of fetal thoracic lesions. *Semin Perinatology* 18:228-253, 1994.

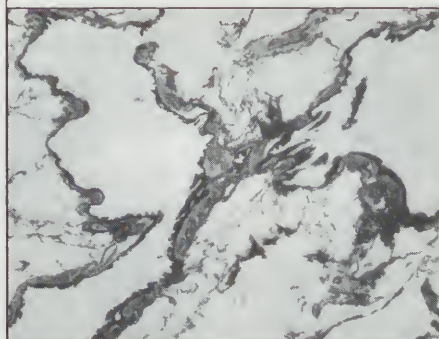


Figure 4. Microscopic section demonstrating respiratory epithelial lining similar to that of a bronchus.

9. Sakala EP, Perrott WS, Grube GL: Sonographic characteristics of antenatally diagnosed extralobar pulmonary sequestration and congenital cystic adenomatoid malformation. *Obstet Gynecol Survey* 49:647-655, 1994.
10. Sargent MA, Liu PC, Smith CR, Daneman A: Infradiaphragmatic pulmonary sequestration. *Can Assoc Radiol J* 43:208-211, 1992.
11. Fraser RG, Paré PD, Fraser RS, Genereux GP: *Diagnosis of Diseases of the Chest, Vol. II, 3d Edition*. Philadelphia, PA, WB Saunders Co., 1989.
12. Kirks DR: *Practical Pediatric Imaging, Diagnostic Radiology of Infants and Children, 2d Edition*. Boston, MA, Little, Brown and Company, 1991.
13. Hayakawa K, et al.: Massive hemoptysis from a pulmonary sequestration controlled by embolization of aberrant pulmonary arteries: Case report. *Cardiovasc Intervent Radiol* 14:345-348, 1991.
14. Buckwalter KA, Gross BH, Hernandez RJ: Bolus dynamic computed tomography in the evaluation of pulmonary sequestration. *J Comput Tomogr* 11:335-340, 1987.
15. Ikezoe J, Murayama S, Godwin JD, Done SL, Verschakelen JA: Bronchopulmonary sequestration: CT assessment. *Radiology* 176:375-379, 1990.
16. Naidich DP, et al.: Congenital anomalies of the lungs in adults: MR diagnosis. *AJR* 151:13-19, 1988.

Ever wish your broker, your trust officer
and your banker had more in common?



A single vision of your future, for example?

As a physician, you spend a lot of time serving your patients and managing your practice. Where do you find the time to manage the people who manage your financial affairs? At PNC Private Bank, the team of people that manage your financial affairs can be just that: a team. People who work together, with a common goal: to realize your vision of the future. PNC Private Bank brings together under

one roof every service you need, backed by 150 years of professional money management experience and the resources of one of the country's largest financial institutions. No conflicts of interest. No misinterpretations. Just the synergy that can only come when everyone who works with you works with each other as well. Call 1-888-844-1565 to learn more about the difference at PNC Private Bank.

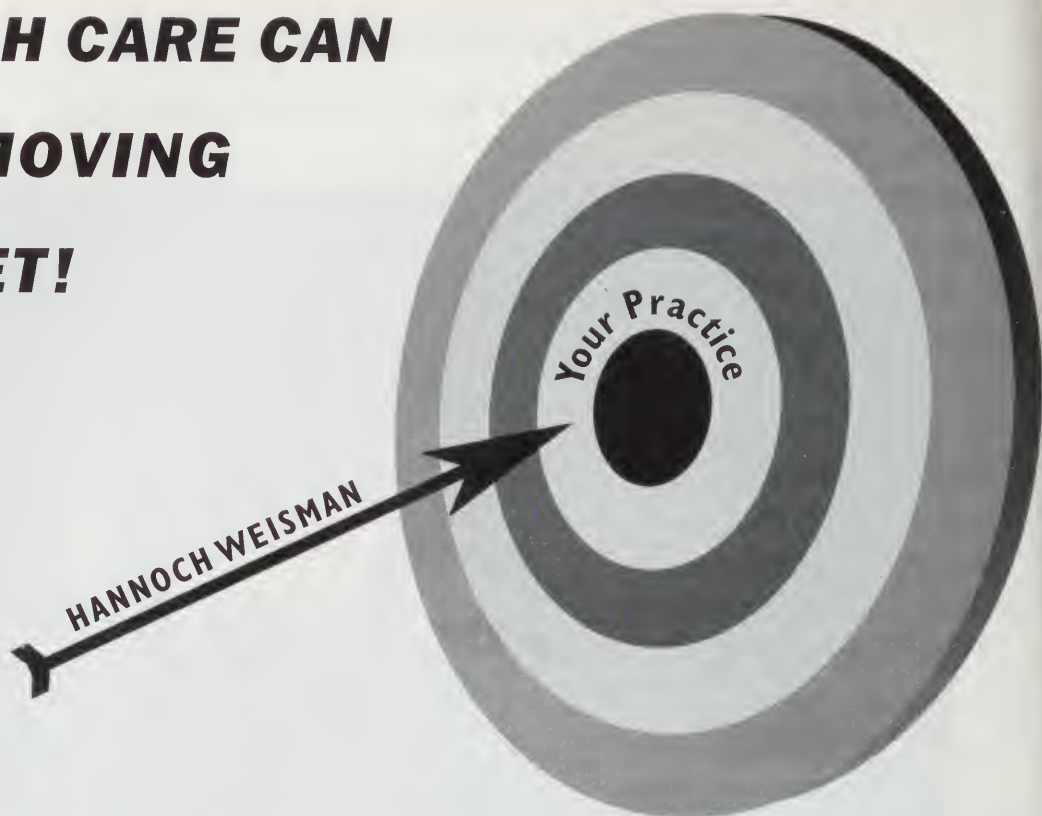
PNC PRIVATE BANKSM

Visit us on the World Wide Web. Our address is <http://www.pncbank.com>

Investments • Trusts • Banking Services

PNC Private Bank is a service mark of PNC Bank Corp. Banking and trust services are provided: by PNC Bank, National Association in Pennsylvania, New Jersey, Kentucky, Ohio and Indiana; by PNC Bank, New England in Massachusetts and Connecticut; by PNC Bank, Delaware in Delaware; and by PNC Bank, FSB in Florida. Members FDIC. Brokerage services are offered through PNC Brokerage Corp, a registered broker-dealer and member SIPC. PNC Brokerage Corp is a subsidiary of PNC Bank, National Association, which is not a broker-dealer.

HEALTH CARE CAN BE A MOVING TARGET!



WHEN YOU CAN'T AFFORD TO MISS . . .

**HANNOCH WEISMAN HAS A RECORD OF HITTING
THE MARK WHEN ADVISING PHYSICIANS ON:**

- ✓ Practice formation, management and operations
- ✓ Review and negotiation of managed care contracts
- ✓ Corporate transactions including mergers and acquisitions and joint ventures
- ✓ Licensing, peer review and disciplinary matters
- ✓ Professional liability and risk management
- ✓ Governmental and payor inquiries and investigations
- ✓ Medical staff relations and credentialing
- ✓ Employee relations and benefits

For assistance or information contact
Lisa D. Taylor, Esq.
James J. Shrager, Esq.


HANNOCH WEISMAN

A Professional Corporation, Counsellors at Law
4 Becker Farm Road, Roseland NJ 07068
973-535-5300

DIAGNOSIS AND TREATMENT OF A SYMPTOMATIC PULMONARY NODULE IN A YOUTH

A CONTINUING MEDICAL EDUCATION EXERCISE

ORIGINAL RELEASE DATE: JUNE 1998

EXPIRATION DATE: JUNE 30, 1999

The University of Medicine and Dentistry of New Jersey (UMDNJ)-Center for Continuing Education in the Health Professions is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education (CME) for physicians.

.....

UMDNJ-Center for Continuing Education in the Health Professions designates this educational activity for a maximum of 1 hour in category 1 credit toward the AMA Physician's Recognition Award, provided it is completed as designed and a minimum passing score of at least 70 percent is achieved. Each physician should claim only those hours of credit that he/she actually spent in the educational activity. Credit for the CME post-test is available until June 30, 1999.

.....

This CME activity was prepared in accordance with the ACCME Essentials.

.....

This activity is directed toward practicing physicians who diagnose or treat patients with pulmonary pathology. After completing this exercise, the participant should be able to:

1. Understand the spectrum of clinical findings of patients with bronchopulmonary sequestration.
2. Become familiar with the pathologic findings in patients with bronchopulmonary sequestration.
3. Discuss the radiologic manifestations of bronchopulmonary sequestration.
4. Describe treatment of this disorder.

.....

CME CONTENT ADVISOR

John L. Noshier, MD

Clinical Professor and Chair, Department of Radiology
UMDNJ-Robert Wood Johnson Medical School, New Brunswick, New Jersey

Developed by UMDNJ-Robert Wood Johnson Medical School, Department of Radiology

Having a financial interest or affiliation with a corporate organization does not prevent an author from participating in a CME activity, but the relationship must be made known in accordance with the Standards of the Accreditation Council for Continuing Medical Education. Each author completed disclosure information forms for this program. Disclosures are described below.

Melissa Chen, MD

Resident, Department of Pathology
UMDNJ-Robert Wood Johnson Medical School
New Brunswick, NJ
No commercial support

David G. Landsnes, MD

Resident, Department of Radiology
UMDNJ-Robert Wood Johnson Medical School
New Brunswick, NJ
No commercial support

John L. Noshier, MD

Clinical Professor and Chair, Department of Radiology
UMDNJ-Robert Wood Johnson Medical School
New Brunswick, NJ
Chief of Radiology Services
Chief, Division of Vascular/Interventional Radiology
Robert Wood Johnson University Hospital
New Brunswick, NJ
Grant/Research Support and Consultant: Terumo Medical Corporation

Randall L. Siegel, MD

Clinical Instructor, Department of Radiology
UMDNJ-Robert Wood Johnson Medical School
New Brunswick, NJ
Member, Division of Vascular/Interventional Radiology
Robert Wood Johnson University Hospital
New Brunswick, NJ
Grant/Research Support and Consultant: Terumo Medical Corporation

Please circle the one best response.

1. Unique pleural envelope separate from that of normal lung.
A. Intralobar sequestration B. Extralobar sequestration C. Both D. Neither
2. Arterial supply from systemic artery.
A. Intralobar sequestration B. Extralobar sequestration C. Both D. Neither
3. More common on left than right side.
A. Intralobar sequestration B. Extralobar sequestration C. Both D. Neither
4. Calcification is common.
A. Intralobar sequestration B. Extralobar sequestration C. Both D. Neither
5. Contiguous with and enclosed within same pleural envelope as normally developed lung.
A. Intralobar sequestration B. Extralobar sequestration C. Both D. Neither
6. Rare cases described in mediastinum and within the pericardium.
A. Intralobar sequestration B. Extralobar sequestration C. Both D. Neither
7. Venous drainage is usually to pulmonary veins and right atrium.
A. Intralobar sequestration B. Extralobar sequestration C. Both D. Neither
8. Presents more often at or after adolescence.
A. Intralobar sequestration B. Extralobar sequestration C. Both D. Neither
9. Represents a developmental malformation.
A. Intralobar sequestration B. Extralobar sequestration C. Both D. Neither
10. All of the following are true statements about lung development **except**:
a. Develops as an outpouching of the primitive foregut.
b. Lung tissue always develops above the diaphragm.
c. When developmental anomalies occur, there may be communication between lung and gastrointestinal tract.
d. Occurs at three weeks' gestation.
e. Aberrant lung may be separated from the remainder of normal lung by its own pleura.
11. All of the following are true statements about extralobar sequestration **except**:
a. Often detected during routine prenatal ultrasound as a cystic or echogenic mass.
b. Symptoms are common, usually secondary to infection.
c. Communication with the gastrointestinal tract is possible.
d. May be associated with eventration or paralysis of the hemidiaphragm.
e. Blood supply arises from the aorta.
12. Venous drainage of extralobar sequestration may be to all the following **except**:
a. Azygos venous system.
b. Inferior vena cava.
c. Internal iliac vein.
d. Hemiazygos venous system.
e. Pulmonary veins.
13. Radiographically, bronchopulmonary sequestration may typically appear as all of the following **except**:
a. A sharply-defined mass not unlike a neoplastic process.
b. A region of obstructive hyperaeration.
c. Lung containing multiple cysts with or without air-fluid levels.
d. A calcified mass.
e. An area of irregular contrast enhancement on CT.
14. Treatment for symptomatic bronchopulmonary sequestration is:
a. Antibiotic therapy.
b. Complete surgical excision.
c. Postural drainage.
d. Radiation therapy.
e. No treatment is required.

Radiology/Pathology Conference at UMDNJ-Robert Wood Johnson Medical School

Shade circle like this: ● Use a **BLUE** or **BLACK** felt tip of ball point pen.

INSTRUCTIONS

- Read the monograph carefully.
- Read each question and record your answers on this form. Retain a copy of this answer sheet for your records.
- Print your name, address, and Social Security number in the spaces below.
- Mail this completed form, with your credit card information or a check or money order for \$25 made payable to: UMDNJ-Center for Continuing Education
P.O. Box 573
Newark, New Jersey 07101-0573
Telephone (973) 972-4267
- Your answer sheet will be graded, and you will be advised whether you have passed or failed.
- A minimum score of 70 percent correct must be obtained in order for credit (AMA/PRA 1.0 credit hour) to be awarded. Credit for this CME post-test is available until June 30, 1999.

1	(A) (B) (C) (D)	4	(A) (B) (C) (D)	7	(A) (B) (C) (D)	10	(A) (B) (C) (D) (E)	13	(A) (B) (C) (D) (E)
2	(A) (B) (C) (D)	5	(A) (B) (C) (D)	8	(A) (B) (C) (D)	11	(A) (B) (C) (D) (E)	14	(A) (B) (C) (D) (E)
3	(A) (B) (C) (D)	6	(A) (B) (C) (D)	9	(A) (B) (C) (D)	12	(A) (B) (C) (D) (E)		

First Name _____	I. _____	Last Name _____	Social Security Number
Number & Street Address _____			____ - ____ - _____
City _____	State _____	Zip Code _____	
Affiliation _____			Degree _____
Day Phone _____	Fax _____		
Enclosed is my check or money order for \$25 made payable to UMDNJ-Center for Continuing Education, or:			
Charge my:	<input type="checkbox"/> American Express	<input type="checkbox"/> MasterCard	
Card Number: _____			
Expiration Date: _____	Signature: _____		

1	() () ()	() ()	() () () ()
2	() () ()	() ()	() () () ()
3	() () ()	() ()	() () () ()
4	() () ()	() ()	() () () ()
5	() () ()	() ()	() () () ()
6	() () ()	() ()	() () () ()
7	() () ()	() ()	() () () ()
8	() () ()	() ()	() () () ()
9	() () ()	() ()	() () () ()
0	() () ()	() ()	() () () ()

The planning and execution of useful and educationally sound learning materials are guided in large part by unput from learners. Your response to the following will help ensure that future materials are informative and meet the educational needs of users. Thank you for your cooperation.

- Having completed this exercise, are you better able to:
 - Understand the spectrum of clinical findings of patients with bronchopulmonary sequestration; ☐ Yes ☐ No
 - Be familiar with the pathologic findings in patients with bronchopulmonary sequestration; ☐ Yes ☐ No
 - Discuss the radiologic manifestations of bronchopulmonary sequestration; ☐ Yes ☐ No
 - Describe treatment of this disorder. ☐ Yes ☐ No
- The content of this program will help me in my clinical practice. **COMPLETELY DISAGREE** (1) (2) (3) (4) (5) **COMPLETELY AGREE**
- The content is up-to-date and current. **COMPLETELY DISAGREE** (1) (2) (3) (4) (5) **COMPLETELY AGREE**
- The content is clear and well organized. **COMPLETELY DISAGREE** (1) (2) (3) (4) (5) **COMPLETELY AGREE**
- The content is balanced and free of commercial bias. **COMPLETELY DISAGREE** (1) (2) (3) (4) (5) **COMPLETELY AGREE**
- For purposes of future planning, please list topics that would be of interest to you:

- Comments:

Only MIIX offers



the Toolkit that fits in your briefcase.

Provided by MIIX Financial Services

The MIIX Toolkit, designed specifically for physicians, explains how you can access:

- **Preferred Purchasing Alliance** — offering discounts up to 70% on quality medical and office supplies and equipment.
- **Equipment Leasing** — equipment lease financing and lines of credit at competitive rates.
- **Receivables Management** — providing collection of medical accounts receivable.

To find out more about this powerful resource,
call MIIX Financial Services at

1-800-227-MIIX.

Endorsed by the

Medical Society of New Jersey

MSNJ

MEDICAL INTER-INSURANCE EXCHANGE



RICHARD LEHMAN

The NEW JERSEY MEDICINE Interview

MSNJ MEMBER RICHARD LEHMAN, MD, IS ONE OF THE FEW NEUROSURGEONS IN THE COUNTRY PERFORMING PALLIDOTOMY. THIS PROCEDURE DESTROYS A SMALL SECTION OF THE BRAIN CALLED THE GLOBUS PALLIDUS. SURGEONS DRILL A HOLE INTO THE SKULL AND INSERT A THIN ELECTRODE. THE HEAT FROM THE ELECTRODE NEUTRALIZES A CLUSTER OF OVERACTIVE CELLS THAT ARE RESPONSIBLE FOR MANY OF THE SYMPTOMS OF PARKINSON'S DISEASE. THE SURGERY OFTEN CAN RESTORE MOBILITY AND REDUCE TREMORS, PROVIDED THAT THE SURGEON PINPOINTS THE EXACT CLUSTER OF CELLS RESPONSIBLE FOR THE PATIENT'S SYMPTOMS.

Diane Haring Cornell

Q. Who are the best candidates for this type of surgery?

A. The patients that are good candidates for pallidotomy are those who have tremor, rigidity, and slowness of movement of the limb, the three cardinal symptoms of Parkinson's disease and whose disease is continuing to progress as medication becomes less and less effective. In other words, they are

having motor fluctuations and the prior good effect of L-dopa medicine on their symptoms now is escaping them.

We can anticipate at least an 80 percent reduction or relief—not necessarily a total amelioration—of rigidity and the limb slowness of movement. We sometimes do less well with tremor, but, in a refractory patient, that sometimes can be

combined with a thalamic lesion to ameliorate the tremor.

Other patients who do well with the surgery are those that have the dyskinesia secondary to the L-dopa medicine.

Q. How long do the effects of this surgery last?

A. Surgery is not a cure. It makes some of the unbearable bearable. The disease is progressive. The amelioration of tremor and the improvement of rigidity will hold. Bradykinesia will slip somewhat and the amelioration of dyskinesia that can occur from the medication used in the treatment of the disease holds very strong. We're just starting to have a significant group of patients that are out at least two years or more postoperatively to study and make some further statements. I think if some of these patients even have a

In the Spotlight

three-year amelioration of symptoms—if they can go through three years of being markedly improved—I think they are and will be very grateful. I think that we now have a significant number of patients out there two, three, and four years postoperatively to be able to evaluate the data and make some positive statements. Certainly, even without a formal study, we can say that the surgery has a positive offering for those patients who have severe motor fluctuations, have dyskinesia, and have been on very adequate trials on medication and are not responding. But the ultimate answer for patients with Parkinson's disease isn't surgery.

Q. When did you start performing the surgery?

A. We did our first surgery at UMDNJ-Robert Wood Johnson University Hospital in February 1993 for a patient who was somewhat end-stage Parkinson's disease with severe dyskinesia secondary to the medication. That



Richard Lehman, MD

patient and another one with severe dyskinesia had very good results. Then we had a quiescent period where we did only the occasional case and then when the ABC *Prime Time* television show came out on the procedure, we were flooded with cases.

At that time I was one of only a few neurosurgeons in the country doing the procedure. We had a number of patients and we had our growing pains.

Q. What is unique about your approach?

A. What's unique is that we are able to take electrical activity in a region rather than look for it in one or a small group of cells and make

recordings and decisions off of that. A computer does the on-line analysis, so that in real time we can analyze that electrical information and make decisions. If we can find a region, if we can, so to speak, to a little more of the forest rather than a single tree, we can shorten the procedure. The hunt for a particular tree in the forest or a few trees in the forest obviously takes longer than finding the forest. Unlike some others doing pallidotomy, there's no specific computer analysis, just a demonstration of the target or trees. Whereas, we look at what sort of forest and determine that is all redwoods, or all pines, or oak and if it's oak then that's where we need to be in terms of making a lesion of the abnormal cells. When we want to go by what we see on the images may not necessarily be where we need to do lesioning for that particular patient. And that's where Dr. Evangelia Tzanakou and the electrophysiologic data she gathered become important. She may say you're in the right township but we need to go to this little stand of trees

ner than that other one. As a consequence, our accuracy has gone and the tendencies for complications have been markedly reduced. The sense of effectiveness of the patient and the lack of side effects have been the keynote in this and I believe in the last 25 or more cases—almost 30 cases—we have not had a major side effect. I think that's in part to her helping us develop a track record and changing some surgical things that we do.

We also don't use micro-stimulation, we use macro-stimulation. After the electrical recordings, we stimulate and we look for possible side effects. In other words, are we too close to the motor messages and when we stimulate do we start getting motor activity rather than worse tremor or worse rigidity? With the electrophysiologic spontaneous recordings that Dr. Tzanakou analyzes and this stimulation, we feel safe to make a lesion. And that has held us in good stead over the last 25 to 30 cases. We are looking now at trying to

superimpose not only the pre- and postoperative images but the preoperative electrical data localization to see how that correlates with early ones as well. And I think that is going to be helpful to the neurosurgical community that is involved in doing pallidotomy.

Q. Is it unusual to operate on an awake patient?

A. No, because that's historically been a part of neurosurgery. At the turn of the century, the anesthesia was not so good; hence, it was better to operate on the awake patient. And then the group at the Montreal Neurological Institute, where I did a one-year sabbatical, popularized the operations on the brain for localization and removal of areas

that are causing seizure, doing their mapping on an awake patient. So we still will operate on some patients awake who have a tumor next to the motor area or near or very close to the speech area and will try to map these areas and avoid them in our resection of the tumor. Operating on the awake patient still is a part of modern neurosurgery.

Q. What do you think the surgery can and can't do?

A. The surgery can't cure patients and can't make them totally normal. I think we can improve their motor function by reduction of tremor, dyskinesia, and rigidity. I think they hold this result. The disease continues and other areas are affected and other manifestations will crop up but the solid motor improvements are held for these patients.

**PALLIDOTOMY CANNOT
CURE PATIENTS AND
CANNOT MAKE THEM
TOTALLY NORMAL.
IT CAN IMPROVE THE
QUALITY OF LIFE.**

Dr. Lehman is an associate professor of neurosurgery at UMDNJ-Robert Wood Johnson Medical School and an adjunct professor of surgery in the Biomedical Engineering Department at Rutgers University.

THE RIGHT PRESCRIPTION FOR YOUR CALLERS



Message-On-Hold Systems

Use your telephone music-on-hold feature to:

- Promote Services
- Reassure Callers
- Educate & Inform
- Encourage Referrals



ORDER ONLINE

PATIENTS ON HOLD LIBRARIES

complete package for **Only \$495**
go to www.holdcom.com/libraries

HOLDCOM

Serving the NJ Healthcare Industry Since 1987

Call 1-800-666-6465
www.holdcom.com

John Paul Dizzia, P.C. ATTORNEYS AT LAW

Legal Counseling and Representation to Medical Professionals in administrative, regulatory and disciplinary matters before the State Board of Medical Examiners, the Department of Insurance, the Division of Medical Assistance and Health Services, and in the law relating to professional rights, responsibilities, ethics and practice issues.

Member:

- National Health Lawyers Association
- Health and Hospital Law Section,
New Jersey Bar Association
- New Jersey Association of
Professional Mediators

108 North Union Ave.
P.O. Box 886
Cranford, N.J. 07016

Call: (908) 276-61
FAX: (908) 276-58
E-mail: JPDLEGAL@AOL.COM



Druker, Rahl & Fein

Business Consultants
Certified Public Accountants

We have your prescription to profitability

We're Druker, Rahl and Fein, the accountants and advisors
to physicians and health care providers.

...Managed Care..Government Regulations

...the industry is changing..quickly.

How will these changes affect your practice?

You have questions and you need answers.

Our medical services' experts will assist you
in developing a strategy to

succeed in this dynamic environment.

Leaders in:

Cost Accounting • Strategic Planning • Group Practice Formation • Tax
Managed Care Analysis • Practice Valuations • Practice Management

200 Canal Pointe Boulevard • Princeton, NJ 08540-5998 • 609-243-9700 • FAX 609-243-9799

Contact Robert J. Rahl, CPA

MAXIMIZING YOUR ASSIGNED INSURANCE RECEIVABLES

al B. Schultz, MD

In this age of managed care, physicians need to determine the most effective way to manage medical billing and, specifically, to optimize the speed and accuracy of assigned insurance payments.

The billing component of a physician's practice is critical and complicated. Invariably, physicians discuss issues associated with billing, such as delays in and/or incorrect insurance payments, accurate coding, and followup of assigned insurance claims. As physicians are faced with shrinking fee schedules for services and as more and more people are joining managed care organizations, the problems and complications associated with billing issues are increasing. This begs the question: "What is the most effective way for physicians to manage their assigned insurance receivables?"

First and foremost, physicians must begin to look at their practices as businesses. To do this, doctors must understand the intricacies, complications, and nuances of medical billing, and, particularly, assigned insurance claims. The most critical component of the business side of practice management is to achieve control of receivables and to maximize cash flow. In today's practice environment,

assigned insurance receivables have become a major, if not the largest, part of receivables. Although achieving control sounds easy, it is very difficult for physicians to find the time to master insurance receivables and billing and train and oversee employees in these matters.

Although anathema to many physicians' beliefs, outsourcing the billing component of a practice actually will increase practice revenue and improve cash flow, while enabling physicians and staff to give their undivided attention to patients' medical needs. Generally speaking, billing firms handle all aspects of medical billing. They review claim forms for compliance with CPT-4 and ICD-9 coding, submit the forms to the insurance companies, and perform the all important followup on submitted claims. Followup is critical because the single biggest factor delaying and, eventually, preventing assigned insurance payments is the pending of assigned claims. The number of causes for pended claims is uncountable. The only way to get paid on a pending claim is to contact the insurance company. Vigilance and followup are essential but, unfortunately, they take time.

Since it is very difficult to devote the time necessary to master all the intricacies of medical billing and provide adequate assigned insurance receivables followup, the question is not whether to use a professional billing company, but rather which type to choose. The best way to find a billing firm is to ask friends and colleagues for referrals. Before a company is selected, though, it is very important to look at the services offered by the firm and see how these services match particular needs. Selected medical billing firms offer "advance funding," a unique service that pays physicians on assigned primary claims within 72 business hours. This is the single most effective way to rapidly improve a practice's cash flow.

Deferring to a medical billing specialist allows physicians to concentrate exclusively on patient care. Many physicians have found that the prescription for a financially strong, healthy practice is to allow the billing experts to take control of the billing and assigned insurance side of practice management.

Dr. Schultz is medical director, Medi-Bill Associates, Inc., Fishkill, New York. He is affiliated with Englewood Hospital, and with Mount Sinai Hospital and Lenox Hill Hospital.

Editorial Guidelines

The principal aim in the preparation of a contribution should be relevance to health care and to the education of health care professionals. The contents of each issue include an important health care development; an in-depth interview highlighting a health care newsmaker; an update on a key public health issue; a peer-reviewed clinical report; brief highlights of the latest events and findings in the health care industry; and a monthly forum for readers. Proposals for special submissions will be considered on an individual basis. Letters to the editor are welcome and will be edited and published as space permits. Notices of events, programs, and meetings are encouraged.

Copyright

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or separate statement accompanying material offered to *New Jersey Medicine* must contain the following language, and must be signed by all authors.

"In consideration of *New Jersey Medicine* taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey in the event that such work is published in *New Jersey Medicine*."

Publication Policy

New Jersey Medicine will review original unpublished materials on topics relevant to health care professionals in New Jersey. All submissions are subject to peer review and are edited to conform to the style of *New Jersey Medicine*. Receipt of materials will be acknowledged. Final decision is reserved for the editor. No direct contact between the reviewers and the

authors will be permitted. Upon acceptance, authors will have the opportunity to review edited material. All communications should be sent to *New Jersey Medicine*, Two Princess Road, Lawrenceville NJ 08648.

Specifications

Materials compatible with Microsoft Word 97 for Windows should be submitted on diskette (3 1/2 inch), and should be accompanied by a printed copy of the material, a cover letter identifying the submission, and a copyright form.

The title page should include the full names, degrees, and affiliations of all authors, and the name and address of the author to whom correspondence should be sent.

The author(s) should submit a 50-word abstract to be used at the beginning of the article. References should not exceed 20 citations and should be cited consecutively by superscripted numbers at the end of the sentence. The style of *New Jersey Medicine* is that of *Index Medicus*: 1. Goldwyn RM: Subcutaneous mastectomy. *NJ Med* 74:1050-1052, 1977. Tables and graphs should be presented at the end of the article. Illustrations should be of professional quality, black and white glossy prints. The name of the author, figure number, and top of the figure should be clearly marked on the back of each illustration. When photographs of patients are used, the subjects should not be identifiable or publication permission signed by the subject or responsible person must be included. Materials taken from other publications must give credit to the original source. Generic names should be used with proprietary names indicated parenthetically with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol.

MEDICARE AUDITS BY THE NUMBERS

XACT IS PERFORMING LARGE NUMBERS OF MEDICARE AUDITS THAT PLACE PHYSICIANS AT SIGNIFICANT EXPOSURE. TO REDUCE EXPOSURE, EVERY MEDICAL PRACTICE SHOULD HAVE A COMPLIANCE REVIEW PERFORMED. TO ASSURE CONFIDENTIALITY OF THE RESULTS AND AVOID CREATING EVIDENCE THAT COULD LEAD TO AN INDICTMENT, THIS REVIEW SHOULD BE CONDUCTED UNDER THE DIRECT AUSPICES OF HEALTH CARE COUNSEL.

even I. Kern, Esq

The number of audits conducted by Xact Medicare has soared. While conducted by Xact, the audit process, by Xact's own admission, is inexact. The results can be potentially devastating. Xact will ask the physician for a sample of 40 to 50 patient charts, corresponding, generally, to one or more CPT codes used in the physician's practice. The codes selected often are those that the physician uses with greater frequency than ordinarily expected in similar primary or specialty practices, based upon regional averages.

Xact, using 1995 recordkeeping criteria, then will downcode the claims associated with these charts, if its review of the charts indicates that the documentation does not meet the requirements of the submitted code. Xact then extrapolates its findings to the general population of Medicare patients in the

physician's practice. For example, if a change in one code resulted in a \$40 reduction in fee in 30 of 40 charts reviewed, Xact will assume that 75 percent of all claims submitted under that CPT code were overbilled by \$40. If the physician had billed this code 2,000 times, Xact would conclude that 1,500 of these claims were overbilled by \$40 and demand repayment of

\$60,000, plus interest and the costs associated with the audit.

Remarkably, in its letter demanding repayment, Xact advises the physician that the sample upon which it makes its initial demand is statistically invalid. Nonetheless, it provides the physician with three alternatives. Alternative one is to accept the unscientific, invalid sample as if it were valid, and repay the

money. Alternative two is not to contest Xact's findings, to waive the right to a statistically valid sampling, and to waive the right to a hearing. In return for giving up these rights, Xact will allow the physician to offer an explanation in an attempt to convince Xact that its initial findings are incorrect. In so doing, the physician is at the mercy of Xact, since Xact has no obligation to accept the explanation, and since the physician has waived all rights to a hearing or appeal from the final determination. Alternative three is to demand a hearing. The right to a hearing does not come without substantial cost. Xact tells the physician that if the physician wants to exercise the right to demand a hearing, it will conduct a complete review of all of the physician's Medicare files, creating the possibility that the physician will be exposed to greater liability.

Xact is telling the physician to pay the amount demanded as a result of an admittedly statistically invalid sampling of charts; to waive the right to a hearing with the hope Xact will listen to the physician's explanation but with no right to appeal if Xact does not; or that the physician be exposed to a full-blown audit of the medical practice.

The amounts demanded by Xact have ranged from \$30,000 to nearly \$1 million. Before making a determination as to which option to elect, a physician must conduct an internal review of the practice and

an analysis of the potential risks and benefits associated with each option. Such an analysis is complicated by the fact that the state Board of Medical Examiners (BME) and managed care companies are asking physicians whether they have ever been required to return monies to third-party payors, including Medicare. An affirmative response can have significant repercussions.

Further complicating the problem is the concern that the physician could be required to turn over all evidence of the internal evaluation to government agents or third-party payors at a later time, since any review performed internally by the practice is not privileged.

To guard against the likelihood that an internal review and analysis may become discoverable and form the basis for more severe legal action, internal compliance reviews and practice audits must be conducted under the auspices of an attorney, so that the attorney-client privilege can help avoid disclosure of adverse findings to third parties. Otherwise, any discrepancies uncov-

ered in the course of an internal review may have to be disclosed to BME, a government or other third-party payor, or other federal or state agency, at a later time. Evidence of prior inappropriate claims, or non-compliance with law, could form the basis for disciplinary action and claims of false or fraudulent billing, which carry enormous financial penalties for the physician, the possibility of incarceration, and loss of medical license.

No physician should undertake any review of billing or coding practices, nor engage in any internal compliance review, other than through legal counsel. Otherwise, the physician's affirmative efforts to achieve compliance could create the opposite result: providing the evidence that results in civil or criminal action against the physician who attempts to assure future compliance.

Given the myriad state and federal laws and regulations at issue, given the huge exposure physicians have, and given the risk of doing nothing, every physician must consider retaining health care counsel and working with management and coding specialists, to perform a compliance audit of a medical practice. ■

**XACT ASKS THE PHYSICIAN
TO PAY THE AMOUNT
DEMANDED AS A RESULT
OF AN ADMITTEDLY
INVALID SAMPLING
OF CHARTS.**



ALLEGHENYSM UNIVERSITY HOSPITALS H A H N E M A N N

Grand Rounds and Medical Seminars

September, 1998 through May, 1999

Grand Rounds 8:30 a.m.-9:30 a.m.

Visiting Professorships 8:30 a.m.-12:00 noon

Medical Seminars 8:30 a.m.-3:30 p.m.

Lecture Hall A/B

2nd Floor College Building, Allegheny University Hospitals, Hahnemann

15th & Vine Streets (16th Street Entrance), Philadelphia

For more information, contact the Office of Continuing Medical Education at 215-762-8263.

OCTOBER 1998

OCTOBER 7th
Absorption
bert M. Craig, M.D.
Professor of Medicine
Western University School of Medicine
ef, Division of Gastroenterology
Western Medical Center
cago, IL

OCTOBER 14th
**Community Acquired Pneumonia:
Late on Diagnosis and Therapy**
hael S. Niederman, M.D.
Professor of Medicine
NY, Stony Brook
ef, Division of Pulmonary and
tical Care Medicine
throp University Hospital
neola, NY

OCTOBER 21st
**Interpretation of Randomized Trials and
Their Application in Clinical Practice**
bert L. Frye, M.D.
Professor and Chair
Department of Internal Medicine
rdiovascular Consultant
e Mayo Clinic
chester, MN

OCTOBER 28th
Ant Cell Arteritis
uce Hoffman, M.D.
Professor of Medicine
Allegheny University of the Health Sciences
Chief, Division of Rheumatology/Immunology
Allegheny University Hospitals, MCP

NOVEMBER 1998

NOVEMBER 4th
Surviving Heart Failure
William Parmley, M.D.
Professor of Medicine
University of California at San Francisco
Chief, Division of Cardiology
Moffet/Long Hospital
San Francisco, CA

NOVEMBER 11th
Diagnosis and Management of Lung Cancer
Joseph Treat, M.D.
Professor of Medicine
Director, Thoracic Oncology
Allegheny University Hospitals

NOVEMBER 18th
Syndrome X: Ten Years of Experience
Gerald M. Reaven, M.D.
Professor of Medicine
Stanford University School of Medicine
Stanford, CA

NOVEMBER 25th
No Grand Rounds—Thanksgiving Holiday

DECEMBER 1998

DECEMBER 2nd
JNC-VI
Ray W. Gifford, M.D.
Professor of Internal Medicine
Ohio State University College of Medicine
Consultant, Department of Nephrology and Hypertension
Cleveland Clinic Foundation
Cleveland, OH

Kenneth A. Jamerson, M.D.
Associate Professor of Internal Medicine
Department of Internal Medicine
Division of Hypertension
University of Michigan Medical Center
Ann Arbor, MI
Marvin Moser, M.D.
Clinical Professor of Medicine
Yale University School of Medicine
Senior Medical Consultant
National High Blood Pressure Education Program
National Heart, Lung and Blood Institute
Bethesda, MD

DECEMBER 9th
Cardiac Auscultation
Bernard L. Segal, M.D.
Professor of Medicine
Allegheny University of the Health Sciences
Philadelphia, PA

DECEMBER 16th
Type II Diabetes Mellitus
Jay Skyler, M.D.
Professor of Medicine
University of Miami School of Medicine
Miami, FL

DECEMBER 23rd
No Grand Rounds—Christmas Holiday
DECEMBER 30th
No Grand Rounds—New Year's Holiday

Wednesday Medical Seminar Series—8:30 a.m. to 3:30 p.m.

OCTOBER 14, 1998

Diagnosis and Treatment of Pulmonary Infection
Course Director: Edward S. Schulman, M.D.
Seminar Director: Allan B. Schwartz, M.D.

NOVEMBER 11, 1998

Advances in the Management of Lung Cancer
Course Director: Joseph Treat, M.D.
Seminar Director: Allan B. Schwartz, M.D.

DECEMBER 9, 1998

Cardiac Auscultation for Office Practice
Course Director: Bernard L. Segal, M.D.
Seminar Director: Allan B. Schwartz, M.D.

DECEMBER 2, 1998

**Update on the Management of Hypertension:
JNC-VI**
Course Director: Bonita Falkner, M.D.
Seminar Director: Allan B. Schwartz, M.D.

Seminar Director: Allan B. Schwartz, M.D., Professor of Medicine, Chief of Service, Director of Continuing Medical Education for the Department of Medicine

Full Disclosure Statement: All faculty participating in continuing medical education programs sponsored by Allegheny University of the Health Sciences are expected to disclose to the audience any real or apparent conflict(s) of interest related to the content of their presentation.

Statement of Accreditation: Allegheny University of the Health Sciences is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education programs for physicians. Allegheny University of the Health Sciences designates 1.0 credit hour of category I of the Physician's Recognition Award of the American Medical Association for each hour of attendance at these continuing medical education activities. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

This program is eligible for 1.0 credit hour for each hour of attendance in category 2A of the American Osteopathic Association.

CALENDAR

EVENT

DATE

LOCATION

October

**Radiological Society of New Jersey and Diagnostic
Radiology Section Meeting**

October 15, 1998

Cooper Health System, Camden, AMNJ, 609.275.1911

**Bringing Caregivers Closer to the Patient:
A Wishlist for the 21st Century**

October 16, 1998

Sheraton, Atlantic City Convention Hotel, Atlantic City, 212.781.5990

Lyme Disease and Chronic Fatigue Syndrome

October 17, 1998

College of Physicians and Surgeons, New York, 212.781.5990

HealthPak '98

October 20, 1998

Hyatt Regency, Tampa, Florida, 717.291.5609

Colitis

October 21, 1998

St. Mary's Hospital, Passaic, AMNJ, 609.275.1911

Interhospital Endocrine Rounds

October 21, 1998

University Hospital, Newark, AMNJ, 609.275.1911

Medical Grand Rounds

October 21, 1998

VA Medical Center, East Orange, AMNJ, 609.275.1911

Endocrinology Lecture

October 21, 1998

VA Medical Center, East Orange, AMNJ, 609.275.1911

Alzheimer's Disease

October 28, 1998

St. Mary's Hospital, Passaic, AMNJ, 609.275.1911

Interhospital Endocrine Rounds

October 28, 1998

University Hospital, Newark, AMNJ, 609.275.1911

Medical Grand Rounds

October 28, 1998

VA Medical Center, East Orange, AMNJ, 609.275.1911

Endocrinology Lecture

October 28, 1998

VA Medical Center, East Orange, AMNJ, 609.275.1911

Diagnosis and Management of HIV/AIDS

October 29, 1998

VA NJ Health Care System, Lyons, AMNJ, 609.275.1911

Dermatology for Primary Care

October 31, 1998

College of Physicians and Surgeons, New York, 212.781.5990

November

Chronic Bronchitis

November 4, 1998

St. Mary's Hospital, Passaic, AMNJ, 609.275.1911

Child Sexual Abuse and Neglect

November 4, 1998

Union Hospital, Union, AMNJ, 609.275.1911

Violence Institute of New Jersey at UMDNJ

November 4, 1998

Dept. of Health and Senior Services, Trenton, AMNJ, 609.275.1911

Vascular Society Meeting

November 4, 1998

New Jersey Performing Arts Center, Newark, AMNJ, 609.275.1911

Interhospital Endocrine Rounds

November 4, 1998

University Hospital, Newark, AMNJ, 609.275.1911

Medical Grand Rounds

November 4, 1998

VA Medical Center, East Orange, AMNJ, 609.275.1911

Endocrinology Lecture

November 4, 1998

VA Medical Center, East Orange, AMNJ, 609.275.1911

Treatment of Depressed HIV Patients

November 5, 1998

Carrier Foundation, Belle Mead, AMNJ, 609.275.1911

MRI Symposium

November 6, 1998

Somerset Marriott, Somerset, AMNJ, 609.275.1911

Psoriasis

November 10, 1998

The Manor, West Orange, AMNJ, 609.275.1911

INTERNATIONAL COLLEGE OF ACUPUNCTURE & ELECTRO-THERAPEUTICS

(Permanently Chartered by the University of the State of New York,
State Education Department)

ACUPUNCTURE & ELECTRO-THERAPEUTICS in Clinical Practice

1998-99 Seminars & Workshops

25 credit hours can be earned by attending
one three-day weekend (Friday-Sunday) session 9 am-7 pm

Nov. 20-22, 1998 Holiday Inn, Manhattan
Dec. 11-13, 1998 440 W. 57th St, NYC between 9 & 10 Ave.
Jan. 22-24, 1999 Hotel tel. 212-581-8100 during meetings
Feb. 19-21, Mar. 19-24, May 14-16, June 18-20, 1999

4th Annual International Symposium, Oct. 22-25, 1998

Columbia University, School Int'l Affairs,
Dag Hammarskjold Lounge, 420 West 118th St., NYC

In addition to holding 7-8 seminars & workshops per year, the International College of Acupuncture & Electro-Therapeutics organizes an Annual International Symposium every October at the School of International Affairs, Columbia University, NYC and publishes *Acupuncture & Electro-Therapeutics Research*, *The International Journal* quarterly, through Cognizant Communications and is listed by 15 major international indexing periodicals (*Index Medicus*, *Current Content*, *Excerpta Medica*, etc.), is recognized as a major leading journal in the field. The most prestigious and internationally recognized, "Fellow of the International College" (F.I.C.A.E.) will be awarded to members of the College who present a minimum of 2 original research papers during the annual International Symposium and publish them in the official journal, or who have made significant contributions in the field.

These seminars workshops int'l. symposium train physicians and dentists in the latest theories & techniques of manual & electro-acupuncture. For information, contact Dr. Y. Omura, MD, ScD, FICAE, 800 Riverside Drive (8-1), NY, NY 10032; 212-781-6262, Fax 212-923-2279 or Dr. Richard Simon, PhD, 212-662-7022. All ICAE meetings are accredited by the New York State Boards for Medicine and Dentistry towards 300-hour requirement for the Acupuncture Certificate. Also eligible for AMA/CME Category I Credit. This activity implemented in accordance with ACCME, joint sponsorship CE Program MSSNY and SUNY Health Science Center, Brooklyn. MSSNY is accredited by the ACCME to provide CME for physicians. MSSNY designates this CME activity for category one credit towards the AMA/Physician's Recognition Award.

The Medical Manager[®]

Practice Management Software

A fully integrated practice management solution

Over 16 years' experience in providing
healthcare automation solutions

Provides an open system architecture
and flexibility for specialized needs

Designed for small group practices to large
Integrated Delivery Systems

Overwhelming national presence

Learn more about how Medical Manager Corporation and
The Medical Manager system can meet your needs. Contact us
at 800.677.7784, 201.808.0088, or www.medicalmanager.com.

Medical Manager

Corporation

RTI, Inc. and Medix

Empowering the Industry Through Partnership

DEBORAH HEART & LUNG CENTER • DEPARTMENT OF PULMONARY MEDICINE

CME Course

15TH ANNUAL CLINICAL UPDATE IN PULMONARY MEDICINE

Saturday, December 5, 1998 • Atlantic City Convention Center • Atlantic City, NJ

Designed for Pulmonologists, Internists, Family Practitioners, General Practitioners and Allied Health Professionals

6.75 Credit Hours Category 1 AMA and AAFP

6.75 Credit Hours Category 2-A AOA

PROGRAM

The Role of Leukotriene Modifiers in the Treatment of Asthma James E. Fish, MD
Upper Respiratory Tract Infections: Treatment and Complications Dennis G. Maki, MD
New Developments in Obstructive Sleep Apnea Allan I. Pack, MD, PhD
Diagnosis and Treatment of Fungal Infections of the Lung Dennis G. Maki, MD
New Treatment Strategies in Adult Respiratory Distress Syndrome ... James E. Gadek, MD
Update on the Management of COPD Michael A. Gripl, MD
Diagnosis and Management of Interstitial Lung Disease James E. Gadek, MD
New Developments in the Early Detection of Lung Cancer David M.F. Murphy, MD

For further information, please contact:

CME Department

Center for Bio-Medical Communication, Inc.

433 Hackensack Avenue, 9th Floor, Hackensack, New Jersey 07601

201/342-5300 Fax: 201/342-7555 E-mail: cmeinfo@cbcbiomed.com

CALENDAR

EVENT

DATE

LOCATION

November

Effects of Violence and Trauma on Children	November 10, 1998	Carrier Foundation, Belle Mead, AMNJ, 609.275.1911
Leukemia	November 11, 1998	St. Mary's Hospital, Passaic, AMNJ, 609.275.1911
Society of Surgeons Meeting	November 11, 1998	Monmouth Medical Center, Long Branch, AMNJ, 609.275.1911
Interhospital Endocrine Rounds	November 11, 1998	University Hospital, Newark, AMNJ, 609.275.1911
Medical Grand Rounds	November 11, 1998	VA Medical Center, East Orange, AMNJ, 609.275.1911
Endocrinology Lecture	November 11, 1998	VA Medical Center, East Orange, AMNJ, 609.275.1911
Chronic Bronchitis	November 12, 1998	VA NJ Health Care System, Lyons, AMNJ, 609.275.1911
ADD and Learning Disabilities in Children	November 12, 1998	Hackensack Medical Center, Hackensack, AMNJ, 609.275.1911
Psychiatry in Primary Care	November 14, 1998	College of Physicians and Surgeons, New York, 212.781.5990
New Jersey Society of Anesthesiologists	November 17, 1998	Forsgate Country Club, Jamesburg, AMNJ, 609.275.1911
Gastroenterological Society Dinner	November 18, 1998	The Manor, West Orange, AMNJ, 609.275.1911
Emerging Infectious Diseases	November 18, 1998	St. Mary's Hospital, Passaic, AMNJ, 609.275.1911
Opportunistic Infections in Patients with HIV	November 18, 1998	Vineland Developmental Center, Vineland, AMNJ, 609.275.1911
Interhospital Endocrine Rounds	November 18, 1998	University Hospital, Newark, AMNJ, 609.275.1911
Medical Grand Rounds	November 18, 1998	VA Medical Center, East Orange, AMNJ, 609.275.1911
Endocrinology Lecture	November 18, 1998	VA Medical Center, East Orange, AMNJ, 609.275.1911
Therapeutic Communities and Substance Abuse Treatments	November 19, 1998	Carrier Foundation, Belle Mead, AMNJ, 609.275.1911
NJ Society of Pathologists Meeting	November 21, 1998	Robert Wood Johnson Med. School, Piscataway, AMNJ, 609.275.1911
Nephrotoxicity of Common Drugs	November 25, 1998	St. Mary's Hospital, Passaic, AMNJ, 609.275.1911
Interhospital Endocrine Rounds	November 25, 1998	University Hospital, Newark, AMNJ, 609.275.1911
Medical Grand Rounds	November 25, 1998	VA Medical Center, East Orange, AMNJ, 609.275.1911
Endocrinology Lecture	November 25, 1998	VA Medical Center, East Orange, AMNJ, 609.275.1911

December

Elder Mistreatment	December 2, 1998	Union Hospital, Union, AMNJ, 609.275.1911
Chronic Bronchitis	December 2, 1998	Clara Maass Medical Center, Belleville, AMNJ, 609.275.1911
Tumor Board	December 2, 1998	The Hyatt Hotel, New Brunswick, AMNJ, 609.275.1911
Interhospital Endocrine Rounds	December 2, 1998	University Hospital, Newark, AMNJ, 609.275.1911

UPDATE '98:

MANAGEMENT OF DIFFICULT TO HEAL WOUNDS

SYMPOSIUM FOR PHYSICIANS

UPDATE '98: Management of Difficult to Heal Wounds"

A compact but comprehensive half-day program sponsored by the Wound Care Centers® of Northern New Jersey. This program is designed for the busy physician interested in enhancing their clinical expertise in the management of difficult to heal wounds.

DATE: FRIDAY, NOVEMBER 6, 1998

PLACE:



The Manor

PROSPECT AVENUE, WEST ORANGE, NJ 07052

ACCREDITATION FOR C.M.E. CREDITS

Englewood Hospital and Medical Center is accredited by the Medical Society of New Jersey to sponsor continuing education for physicians. Attendance at this program has been designated as providing 4 hours of Category I credits toward the AMA Physicians Recognition Award. Application has been made to the New Jersey Podiatric Society for category 1 credits.

PROGRAM

7:30 A.M. Registration/Exhibits/Continental Breakfast

8:00 A.M. Welcome by Moderator
Mark Doyne, MD
Vice President of Medical Affairs
Curative Health Services - Hauppauge, NY

8:15 A.M. "Etiology of Diabetic Foot Wounds:
Obstacles to Healing"
Marvin E. Levin, MD, FACP
Professor of Clinical Medicine and Associate
Director of the Diabetes, Endocrinology and
Metabolism Clinic at Washington University
School of Medicine - St. Louis, MI

9:00 A.M. "Assessing the Circulatory Status
of the Lower Extremity"
Herbert Dardik, MD, FACS
Director of Vascular Institute and
Chief, Department of Vascular Surgery,
Englewood Hospital and Medical Center,
Englewood, NJ

9:45 A.M. Break

10:00 A.M. "Approaches to the Management of
Chronic Wound Infections"
Catherine J. Hardalo, MD
Associate Clinical Project Director
at Schering Plough Research Institute,
Kenilworth, NJ

10:45 A.M. "Hyperbaric Oxygen and its Adjunctive
Role in Wound Healing"
Eric P. Kindwall, MD
Kindwall Consulting, Brookfield, WI

11:30 A.M. "Wounds of Uncommon Etiologies -
Making the Appropriate Diagnosis"
Vincent Falanga, MD, FACP
Professor and Chairman, Department of
Dermatology and Skin Surgery, Roger
Williams Medical Center, Providence, RI

12:15 P.M. Panel Discussion and Evaluation

12:45 P.M. Buffet Luncheon

REGISTRATION

☐ PLEASE REGISTER ME FOR
THE CONFERENCE ONLY

☐ PLEASE REGISTER ME FOR
THE CONFERENCE AND LUNCH

Name _____

Specialty _____

Hospital Affiliation _____

Address _____

City _____

State _____ Zip _____

Phone (_____) _____

- ▶ NO FEE—BUFFET LUNCH PROVIDED
- ▶ REGISTER EARLY—SPACE IS LIMITED
- ▶ R.S.V.P. BY OCTOBER 30, 1998

MAIL TO: WOUND CARE CENTER®
95 MT. KEMBLE AVE., MORRISTOWN, NJ 07962
OR FAX TO: 973-290-7642

FOR ADDITIONAL INFORMATION, CALL

1-800-447-3337

THE MEDICAL SOCIETY OF NEW JERSEY CLASSIFIED ADVERTISEMENT INSERTION REQUEST

RATES

(Placement in New Jersey *MEDICINE* OR on WEB Site)

	<u>New Jersey <i>MEDICINE</i></u>	<u>http://www.msnj.org WEB Site</u>
Per Month—Non-Members		
Minimum 45 words	\$ 45.00	
plus each word		
over 45 words	\$ 1.00	
Per Month—Members		
Minimum 45 words	\$ 30.00	
plus each word		
over 45 words	\$ 1.00	
Per Month—		
Minimum 45 words		\$ 45.00
plus each word		
over 45 words		\$ 1.00

(Placement in New Jersey *MEDICINE* AND on WEB Site)

	<u>New Jersey <i>MEDICINE</i></u>	<u>http://www.msnj.org WEB Site</u>
Per Month—Non-Members		
Minimum 45 words	\$ 45.00	\$ 36.00
plus each word		
over 45 words	\$ 1.00	\$.80
Per Month—Members		
Minimum 45 words	\$ 30.00	\$ 36.00
plus each word		
over 45 words	\$ 1.00	\$.80

PREPARE YOUR COPY ON A SEPARATE PAGE AND ATTACH TO THIS ORDER FORM

INSERTION AUTHORIZATION

Name _____ MSNJ Member? Yes _____ No _____
 Company _____ Telephone Number _____
 Address _____ Fax Number _____
 City _____ State _____ ZIP _____
 New Jersey *MEDICINE* Issues _____
 Web # of 30 Day Insertions _____

New Jersey *MEDICINE*

Non-Member
 Minimum 45 Words \$ 45.00
 + Each Add'l Word @\$1.00 \$ _____
 Per Issue \$ _____
 X Number of Issues
 AMOUNT DUE \$ _____

MSNJ WEB SITE

Non-Member or Member
 Minimum 45 Words \$ 45.00
 + Each Add'l Word @\$1.00 \$ _____
 Per Month \$ _____
 X Number of Months
 AMOUNT DUE \$ _____

New Jersey *MEDICINE*

Member
 Minimum 45 Words \$ 36.00
 + Each Add'l Word @\$1.00 \$ _____
 Per Issue \$ _____
 X Number of Issues
 AMOUNT DUE \$ _____

MSNJ WEB SITE WITH NEW JERSEY *Medicine* Placement

Non-Member or Member
 Minimum 45 Words \$ 36.00
 + Each Add'l Word @\$.80 \$ _____
 Per Month \$ _____
 X Number of Months
 AMOUNT DUE \$ _____

TOTAL DUE \$ _____ ALL CLASSIFIED ADS MUST BE PRE-PAID

Please make check payable to "Medical Society of New Jersey"

Mail to: Classified Ad Department
 370 Morris Avenue
 Trenton, NJ 08611

Tel: 609-393-7196
 Fax: 609-393-3759

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

(Required by 39 U.S.C. 3685)

1. Title of Publication: *NEW JERSEY MEDICINE*.
2. Publication No.: 0885842X.
3. Date of Filing: September 3, 1998.
4. Frequency of Issue: Monthly.
5. No. of Issues Published Annually: 12.
6. Annual Subscription Price: \$50.
7. Complete Mailing Address of Known Office of Publication: 2 Princess Road, Lawrenceville, Mercer County, NJ 08648.
8. Complete Mailing Address of the Headquarters of General Business Office of the Publisher: 2 Princess Road, Lawrenceville, Mercer County, NJ 08648.
9. Names and addresses of publisher, editor, and managing editor: Publisher: Medical Society of New Jersey, 2 Princess Road, Lawrenceville, NJ 08648. Editor: Howard D. Slobodien, MD, 2 Princess Road, Lawrenceville, NJ 08648. Managing Editor: Geraldine R. Hutner, 2 Princess Road, Lawrenceville, NJ 08648.
10. Owner (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given. If the publication is published by a nonprofit organization, its name and address must be stated.): Medical Society of New Jersey, 2 Princess Road, Lawrenceville, NJ 08648.
11. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages, or other securities: None (a nonprofit corporation of New Jersey).
12. For completion by nonprofit organizations authorized to mail at special rates (DMM Section 423.12 only). The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes have not changed during preceding 12 months.

	Average no. copies each issue during preceding 12 months	Actual no. copies of single issue published nearest to filing date
Extent and nature of circulation		
Total number of copies (net press run)	10,975	9,500
Paid and/or requested circulation		
1. Sales through dealers and carriers, street vendors, and counter sales (not mailed)	—	—
2. Paid or requested mail subscriptions (include advertiser's proof copies and exchange copies)	10,492	9,287
Total paid and/or requested circulation (sum of B1 and B2)	10,492	9,287
Free distribution by mail (samples, complimentary and other free)	340	113
Free distribution outside the mail (carriers or other means)	—	—
Total free distribution (sum of D and E)	340	113
Total distribution (sum of C and F)	10,832	9,400
Copies not distributed		
1. Office use, leftovers, spoiled	143	100
2. Returns from new agents	—	—
Total (sum of G, H1 and H2)	10,975	9,500
Percent paid and/or requested circulation (C/G x 100)	97%	99%

3. I certify that the statements made by me above are correct and complete.

(signed) Geraldine R. Hutner

CLASSIFIED ADS

100 OPENINGS PHYSICIANS (MULTIPLE SPECIALTY LISTINGS)

PODELL MEDICAL CENTER

The Podell Medical Center is looking for physicians who are well-trained in conventional and alternative medicine to join our integrative health and medical care center. Please ask for Judy Aiello. Richard N. Podell, MD, MPH, Clinical Professor, Department of Family Medicine, UMDNJ Robert Wood Johnson Medical School. Telephone: 908-464-3800. Fax: 908-464-3078.

110 OPENINGS PHYSICIANS (ALPHABETICAL BY SPECIALTY)

GASTROENTEROLOGIST

Thirty physician multi-specialty, multi-site group independently owned seeking GI to join as either shareholder or employed physician. Offices located in Ocean and Monmouth Counties. Call 732-295-5942 or mail cv to Administrator, PO Box 1028, Brick, NJ 08724.

INTERNAL MEDICINE

Internal Medicine. Family Practice. Mercer County/Princeton Area. Seeking BC/BE Internist/Family Practitioner to join busy medical practice in the Mercer County, Princeton Area. Competitive Salary, full Benefits Package. Recent Residency Graduates welcomed. Contact Dr. Joseph De Blasio. 609-586-6006.

INTERNAL MEDICINE

BC/BE Internal Medicine, Morris County. Well established private practice. On staff of Morristown Memorial Hospital. Seeking PT/FT associate. Fax Resume: 973-514-1056.

BC/BE PEDIATRICIAN

Part time, Holmdel area, flexible schedule. Fax CV to 732-888-0012.

BC/BE PEDIATRICIAN

Seeking a quality Pediatrician BC/BE to join an expanding practice in suburban Wayne, New Jersey. Excellent salary and benefits. Full partnership in four years. Phone: 973-694-1400. Fax: 973-694-1782.

RADIOLOGIST

Private imaging center by the Jersey Shore is in need of two Board Certified Radiologists; one Full-time with experience & training in MRI & CT & one Part-time with experience in Mammo, Sonogram & Nuclear Medicine. Send resume to Box #140, New Jersey MEDICINE, 370 Morris Avenue, Trenton, NJ 08611.

130 OPPORTUNITY WANTED

GENERAL PRACTICE—ER

51 years old, 23 years medical practice in General Practice and small ER's; seeks only temporary work. Not board-certified or eligible; only 1 year PG. Licensed MO, NJ, Puerto Rico, Virgin Islands. ACLS only. Foreign Graduate (Spain). 314-428-4032.

300 OFFICE RENTALS AND LEASES

EDISON

Office Space—Edison Medi-Plex Building opposite J.F.K. Hosp. Fully equipped, turn-key. Rent day, full day, night. 732-494-6300.

EDISON

Modern Medical Office Space—Sublease Up to 2000 Square Feet. Fully equipped with on-site Surgery Center available. Suitable for Endoscopy, Surgical procedures, etc. Call Denise—732-549-2975.

MARLBORO

Medical Complex—Fully equipped 1200 Square Feet of Medical Office space for Lease—Excellent Location Call Dawn—732-238-7600.

LAKE HOPATCONG— MORRIS COUNTY

Medical Office Space. 2,000 Sq. Ft. Fully equipped. Occupied 35 years. Ideal for partnership or small group. Lake Hopatcong. 973-663-5306.

MILLBURN

Medical Arts Building. Millburn Avenue. Fully equipped, turn key. Rent day, 1/2 day, night. 973-376-8670.

PARSIPPANY-MORRIS PLAIN

Medical Arts Plaza, 2839 route 10 (opposite Powder Mill West), Parsippany-Morris Plains. 925 S.F. Large Waiting Room. Large Patient Office. 2 Exam Rooms with sinks. Utility Ctr. Manager's Office. Work Station with sink/vit. Lavatory. New Carpets. New Central H.C. Professional Atmosphere. Building recently purchased and extensively renovated. Inexpensive Demographics. Plus an additional 1,435 S.F. available soon. Call Owner—973-228-5879.

400 MEDICAL BILLING

MEDICAL BILLING

Announcing from SoftPro Systems: A complete Health Management System/billing package for physicians and labs. Windows based, user friendly, easy and fun to use. Send forms directly to insurance companies. Obtain patient medical records at the click of a button. Schedule appointments. Call immediately for details: 609-936-9200.

520 NEW EQUIPMENT— LEASING/FINANCING

EQUIPMENT LEASING/FINANCING

HPSC specializes in financing healthcare practice equipment, working capital, leasehold improvements, supply contracts, start-ups. Low competitive fixed rates. Response within hour, by phone or fax. Over 72,000 doctors financed with incredible service! \$150,000 application only. All contracts funded, serviced house. We do not sell your contract to disinterested third parties. On practice acquisitions, buy-ins, we finance up to 100% of selling price. Apply over the Internet; www.hpsc.co (secure site)! HPSC Financial Services 800-225-2488, Fax 800-526-0259.



SHORT HILLS

Ideal location for home & office. Gracious 5 bedroom, 3 1/2 bath Colonial in heart of Short Hills. Offered in impeccable condition. Wonderful details including arched doorways, bay windows and hardwood floors. Spacious 5 room attached office with two lavatories zoned for medical professional. Central air throughout. \$695,000. Prudential Brown-Flower Co., REALTORS (908) 766-5666.

EMERGENCY PHYSICIANS

Emergency Physician Associates, a Team Health affiliate, is seeking quality ED physicians for a variety of practice opportunities in NJ, PA, DE, MD, NC and NY.

We offer physicians competitive compensation, flexible schedules, malpractice insurance, a variety of practice settings, and supportive Medical Directors.

Interested candidates may call

1-800-848-EPA-1.

PRIMARY CARE - Part-time

A growing practice, located in Delran, New Jersey & affiliated with Memorial Hospital of Burlington County, is searching for a BC/BE Internal Medicine physician to join two highly respected Internists. To be considered, please forward your C.V. to **Alliance Medical Management, Inc., Attn: Sue Koneschusky, 2615 Rt. 38, Mt. Holly, NJ 08060. FAX: 609-265-7899.** EOE, M/F/D/V.

ALLIANCE

Alliance Medical Management, Inc.

You take care of your patients. We'll take care of the health of your practice. Our group of health care accounting specialists provides the medical community with the right type of analysis and counseling to be successful.

Since we're dedicated to increasing your profitability, never simply reporting it, we'll see

to it that your practice stays healthy for many years to come. To experience our unique approach, please call Ira S. Rosenbloom, Managing Director, at **973-882-1100.**

PRACTICE GOOD FINANCIAL MEDICINE.



Mintz Rosenfeld & Company LLC

Profitability Consultants • Certified Public Accountants

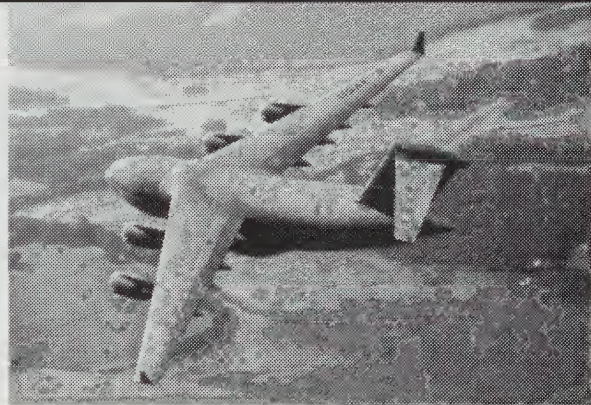
60 Route 46 East, Fairfield, NJ 07004

Tel: 973-882-1100 Fax: 973-882-1560

OUR FOCUS IS YOUR SUCCESS.

PHYSICIANS

**TAKE YOUR
MEDICAL
CAREER
ABOVE &
BEYOND**



APN 25-801-0002

If you're a physician looking for a change of pace above and beyond the ordinary, consider becoming a commissioned officer/physician with the Air Force Reserve. As in civilian life, Air Force Reserve physicians provide critical and preventive care and vital clinical services.

However, as a Reservist, your medical expertise can take you around the globe and into real-world scenarios that will take healing above & beyond. Air Force Reserve physician/officers hold a position of special trust and responsibility. Combined with training opportunities in areas such as Global Medicine and Combat Casualty Care, paid CME activities, you will find yourself among an elite group of health care providers. All it takes is one weekend a month and two weeks per year. Feel the pride of doing something above and beyond for your country while adding a new dimension to your medical career.

Call 1-800-257-1212. Or visit our web site at www.afreserve.com.


**AIR FORCE
RESERVE**
ABOVE & BEYOND

Photo Finish

Each year more than one million women seek medical assistance for injuries caused by battering. Dr. Brian Zack urges all health care professionals to become informed about domestic violence. October is National Domestic Violence Month. For educational materials, 24-hour emergency assistance, and other information in New Jersey call Womanspace at 1.800.572.SAFE.



We welcome contributions to Photo Finish (color or black-and-white). Please include a 50-word description of the photograph. Send to Editor, New Jersey Medicine, Two Princess Road, Lawrenceville NJ 08648. Photographs will be returned.

NEW JERSEY MEDICINE

HEALTH CARE IN THE GARDEN STATE

NOVEMBER 1998

Walter Hughson Hasbrouck, M.D.
10 Crestmont Rd
Montclair, NJ 07042

Medical MISSIONS

*Operation Smile's
global impact*

plus
**Battling the
Wintertime
Blues**

Y - O - U - R

PRACTICE

MADE MORE

PERFECT

WITH OVERHEAD EXPENSE INSURANCE FROM BLANKSTEEN

If you get sick, we'd like to help keep your practice well with overhead expense coverage that can reimburse office salaries, rent, insurance premiums, and utilities during an extended disability. Your needs are special, so call and talk with us. The only time to draw a blank in your insurance is when you fill it in with Blanksteen.



The _____ steen Companies

The Blanksteen Companies 253 Washington Street Jersey City, NJ 07302 201-333-4340 1-800-BLANK-AG
The Blanksteen Companies 161 William Street New York, NY 10038 212-732-9435 1-800-BLANK-AG
The MEDICAL SOCIETY OF NEW JERSEY endorsed plans, including Professional Overhead Expense underwritten by National Casualty Company.

OCT 25 1999

AUSTIN, TEXAS

NewsWatch

Survival of the fittest

Survival in the 20th century may be epitomized by the Royal Air Force's (RAF) decision where to place additional armor plating at its disposal to protect bombers on missions over Europe. Because returning aircraft had been badly hit in diverse places, RAF engineers at first were uncertain which spots most needed protection. Cleverly, they placed the armor where returning aircraft had *not* been hit.

Long-surviving physician enterprises have been hit—criticized—for choosing leaders for charisma and connections rather than competence, for not striking the right balance between public health and physician payment issues, and for building substantial financial infrastructures.

But, long-surviving physician enterprises, such as organized medicine associations, have not been hit for failing to keep a high-profile lobbying presence, or for failing to maintain integrity in public statements and publications, or for supplying bad advice to physicians.

Let's reinforce the work of representatives who can be counted on

for measured and persistent advocacy, and valid and reliable information.

In a lobbying upset, the American Medical Association (AMA) led efforts persuading the Senate to drop the Lethal Drug Abuse Prevention bill. The measure would have banned narcotics prescribing by physicians who participated in assisted suicide. The bill represented a tendency to prevent states from enacting their own health care regulatory approaches. The bill also reflected a dangerous new trend to punish physicians for clinical decisions.

Primary care physicians might refocus their mission, judging from a recent study summarized in the *Healthcare Leadership Review*. Research

trends suggest that the gatekeeper model often does not ensure either cost savings or high quality. Pressures on primary care medicine include new programs of disease management, the rise of hospital intensivists, and greater utilization by managed care organizations of new health practitioners who follow care protocols. Also

demand management systems now direct patients to the right specialist.

The authors advise primary care physicians to enhance their computer skills, learn to collaborate effectively with alternative health care providers, practice population-based medicine involving epidemiologic and public health techniques, improve their management skills, and become con-

Are Medicare HMOs all the rage? New Health Care Financing Administration (HCFA)

projections have been revised sharply downward.

HCFA actuaries now expect seniors' participation in risk-sharing plans to double in the next five years between 25 to 30 percent and then stay flat. So far this year, new enrollments have dropped from last year's record levels, points out

Medicine & Health.

versant with evidence-based practice, applying the results of outcomes research.

As if to illustrate the point, a University of Minnesota study, recently summarized in the Agency for Health Care Policy and Research's *Research Activities*, notes that primary care physicians fail to diagnose depression properly in

one-half of elderly patients, especially men. One-sixth of the elderly are depressed, conclude the researchers.

On the risk-sharing side, another *Healthcare Leadership Review* piece suggests that physicians can benefit from hospital "gainsharing" programs. This innovation aligns physicians' incentives with a hospital's objectives for cost reductions in specific disciplines, such as cardiology. Typical features of gainsharing initiatives include trouble-shooting, identification of major opportunities for savings, monitoring of spending patterns, development of improvement plans, and direct collaboration between clinicians and hospital administrators.

HMOs, too, can save money, according to a study summarized in *Research Activities*. HMOs can achieve this by influencing patients' choice of physicians and furnishing physicians with feedback on cost-effective practices. Ann Barry Flood, PhD, of Dartmouth Medical School, and colleagues adjusted patients' copayments to reward patients for choosing low-cost providers and to penalize them for high-cost choices.

Although patients in the Flood study could access specialists directly, primary care was offered in more convenient sites than specialty care. Most patients tended to

make low-cost choices, with the exception of both very healthy and very sick patients.

"The central goal in health care antitrust enforcement is to ensure that consumers are able to decide what they want in the marketplace, instead of providers' limiting that choice," says Robert F. Leibenluft, assistant director for health care in the Federal Trade Commission's Bureau of Competition. Speaking in a Health Affairs interview, the antitrust top gun observes that health care providers are permitted to join together, even in non-risk-sharing enterprises, if their conduct is likely to create significant cost savings.

HMOs are permitted to consolidate, Mr. Leibenluft notes, so long as an HMO does not control 50 percent or more of a market, does not achieve enough dominance to be able to raise premium prices, or does not maintain so many exclusive arrangements with providers as to preclude other HMOs from entering the market. He further comments that the bureau's staffing has not been increased to accommodate rising antitrust concerns.

Overutilization of antibiotics remains dangerously high. A new report of the Institute of Medicine, summarized in the *Leadership Review*, estimates excessive

use at 25-45 percent in hospitals, 20-50 percent in community settings, and 40-80 percent in agriculture. At an Interscience Conference on Antimicrobial Agents and Chemotherapy, summarized in *Medicine & Health*, researchers stated that one-third of active strains of streptococcal pneumonia already are resistant to azithromycin, clarithromycin, and other broad-spectrum antibiotics.

Survival in a competitive environment also reflects competence in communication. Even in disease management programs, communication that convinces patients to comply now is regarded as the key to success, according to a *Perspectives on the Marketplace* report. The ability to explain health care treatment and issues clearly was rated as extremely important by 82 percent of respondents in the New Jersey Health Care Values Survey last year, coming in just below technical competence, which attained an 87 percent rating.

And, in an article summarized in the *Healthcare Leadership Review* deploring the effects of managed care on physician-patient communication, Peter B. Barnett, MD, concludes, "The physician must establish an environment of trust." Armed with their patients' trust, physicians still will soar in the 21st century.

Neil E. Weisfeld

“THERE IS
NOTHING MORE
EXHILARATING THAN TO BE
SHOT AT WITHOUT
RESULT.”



—WINSTON CHURCHILL

Princeton Insurance Company policyholders are winning the battle against frivolous professional liability claims: 95% of company-managed cases are resolved in our insureds' favor. A successful defense means an unscathed professional reputation *and* preservation of financial security.

In today's legal climate, even the best doctors must dodge a bullet now and then. To marshal the heavy artillery on *your* side, consult one of the independent agents who represent Princeton or call us at 1-800-433-0157.



Princeton Insurance Company

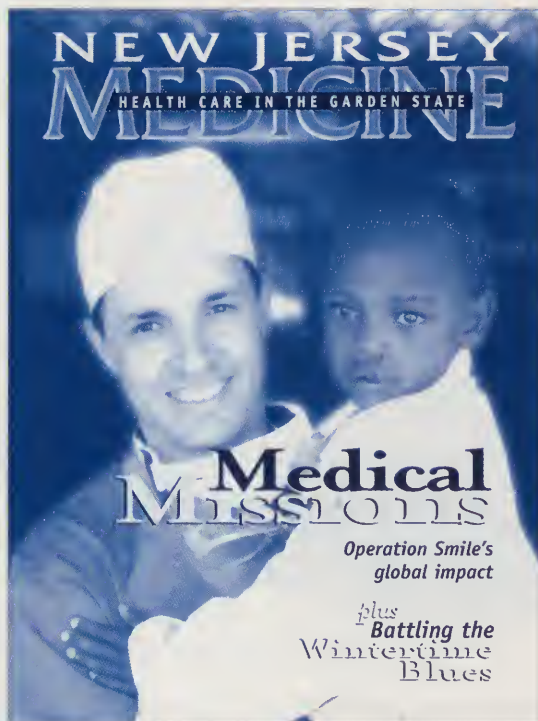
Professional Liability

Office Package Policy

Workers Compensation

Rated A- (Excellent) by A.M. Best Company 746 Alexander Road • Princeton, New Jersey 08540

REASON TO SMILE.



Solid results are all it takes for most marketers to perk up, and that's where we excel.

Call Three Bears today, and let's talk about your audience, your message and its delivery.

We'll show you solutions that are sure to give you plenty of reasons to smile.



THREE BEARS

ADVERTISING • MARKETING COMMUNICATIONS

20 NASSAU STREET, PRINCETON, NJ 08542
609-688-1400

New Jersey Medicine (ISSN-088-5842-X) is published monthly (since 1904) under the direction of the Council on Communications by the Medical Society of New Jersey (MSNJ), Two Princess Road, Lawrenceville, NJ 08648. Printed in Lancaster, PA, by Lancaster Press. Printed in USA. Whole number of issues 1133. Member's subscription (\$10) is included in MSNJ dues. Rates for nonmembers are \$50; outside USA, add \$20. Single copy is \$7.50. Periodicals postage paid at Trenton, NJ, and Lancaster, PA. Copyright 1998 by MSNJ. November 1998. Internet address: <http://www.msnj.org>. E-mail address: info@msnj.org. 609.896.1766. FAX 609.896.1368. Postmaster: Send address changes to *New Jersey Medicine*, Two Princess Road, Lawrenceville, NJ 08648. The appearance of advertising *New Jersey Medicine* is not a MSNJ guarantee or endorsement of the product or service, by the advertiser. When MSNJ has endorsed a product or program, that will be expressly noted.

NEW JERSEY MEDICINE

HEALTH CARE IN THE GARDEN STATE
NOVEMBER 1998

Editor-in-Chief	Howard D. Slobodien, MD
Executive Editor	Geraldine R. Hutner, MA
Assistant Editor	Nancy M. Propsner, BA
Editorial Assistant	Karen Cuozzo, BS
Advertising	Cookson Media Services Ritchie Resource Group Trenttypo, Inc.
Production	Three Bears Communications
Graphic Design	
President and Chair	R. Gregory Sachs, MD
President-Elect	Irving P. Ratner, MD
First Vice-President	Walter J. Kahn, MD
Second Vice-President	Angelo S. Agro, MD
Secretary	Bessie M. Sullivan, MD
Treasurer	Eileen M. Moynihan, MD
Immediate Past-President	Carl Restivo, Jr, MD

MEDICAL SOCIETY OF NEW JERSEY BOARD OF TRUSTEES

S. Manzoor Abidi, MD
Stevan Adler, MD
Churchill L. Blakey, MD
Donald J. Cinotti, MD
Rajendra Prasad Gupta, MD
George T. Hare, MD
David A. Ingis, MD
Philip J. Jasper, MD
Elliot M. Kraus, MD
Giovanni Lima, MD
Mark T. Olesnick, MD
Robert S. Rigolosi, MD
Andrew Kunish, MD, <i>Speaker of the House</i>
John W. Spurlock, MD, <i>Vice-Speaker of the House</i>
Francis J. Lumia, MD, OMSS
Jamsheed K. Najmi, MD, <i>Medical Specialty Societies</i>
Sean C. Reinhardt, <i>Medical Student</i>
Niranjan V. Rao, MD, <i>Member-at-Large</i>
Michael J. Spedick, MD, <i>Member-at-Large</i>
Valerie Claps, <i>MSNJ Alliance</i>
Carlo Porcaro, MD, <i>IMC Section</i>

REVIEW BOARD

Henry Liss, MD, Chair, Paul W. Armstrong, Esq.
Harry M. Carnes, MD, Gary S. Carter,
Elizabeth G. Christopherson,
Stuart Cook, MD, Ellen M. Cosgrove, MD,
The Honorable Len Fishman, Joseph E. Gonzalez, Jr,
Paul J. Hirsch, MD, Ismail Kazem, MD,
Louis L. Keeler, MD, Carol J. Kientz, RN,
James R. Knickman, PhD, Paul R. Langevin, Jr,
George R. Laufenberg, Martin S. Levine, DO,
Gregg Lubinsky, RPh, Ruth B. Mandel,
Michael R. McGarvey, MD, Julane Miller,
Charles M. Moss, MD, Patricia Murphy, PhD, RN,
Tom O'Neill, Fred M. Palace, MD,
Robert Rickert, MD, Mary Todd, DO,
William H. Tremayne, F. Kevin Tylus,
The Honorable Charlotte Vandervalk,
Joan Verplanck, Paul E. Wallner, DO

Wouldn't **you** rather
—
practice medicine
—
than **wrestle**
—
alligators?

Whatever challenges you face or opportunities you contemplate, the right legal counsel can spell the difference between a tangle of complications and a successful outcome.

Tamborlane & Printz focuses decades of experience and insight on your needs regarding managed care contracts, state and federal

We
thought
so.

compliance requirements, and countless other issues.

Call us and speak with the attorneys called upon for guidance by America's most prestigious medical associations and health law publications. We'll help you maximize the rewards and minimize the risks associated with providing quality health care.



Tamborlane & Printz, P.C.

Counselors at Law

New Jersey: 908-789-7977 1044 Route 22 West, Mountainside, NJ 07092

Florida: 305-296-2700 1800 Atlantic Boulevard, Suite 208A, Key West, FL 33040

Email: law@tamborlane.com

22

Focus on health care

Medical volunteers make global impact

By Nancy M. Propsner

New Jersey physicians and health care workers give time and service to help medically underserved children here and abroad.

27

Public health advances

Knock Knock: Concussions from sports injuries

By Rosemarie Scolaro Moser, PhD

Of 1.54 million head injuries, 25 percent are from sporting events. We need guidelines for managing sports-related concussion.

31

Clinical report

Impotence after recovery from Guillain-Barré syndrome

By Kopel Burk, MD; Alan Weiss, PhD

For men recovering from Guillain-Barré syndrome, there has been an increase in impotence compared to the general male population.

35

In the spotlight

Interview with Robert Johnson

By Bill Berlin, PhD

As director of adolescent and young adult medicine, Dr. Johnson is making inroads in adolescent health care.



Kopel Burk, MD
on Guillain-Barré syndrome



Robert Johnson, MD
on adolescent medicine



Lauren Eder, PhD
on year 2000 compliance

Direct AccessSM

for small employers

- Visit a specialist
without a referral.

- Nationwide access to over 300,000 participating doctors, specialists and hospitals.

- Value added discounts for you and your employees from Cole Vision and CompUSA.



And, announcing a \$25,000 life insurance program for small employer groups that join the MSNJ/BCBSNJ program!

This and more is available when you choose the new Direct Access health plan from Blue Cross and Blue Shield of New Jersey—The Medical Society of New Jersey's health carrier of choice for its members!



BlueCross BlueShield
of New Jersey

ISE
INDIVIDUAL &
SMALL EMPLOYER
DIVISION

Ask us for a free
copy of the SEH
Buyer's Guide.

For more information on Direct Access, and other
health plans for individuals, families
and small employers,
contact the Medical Society of New Jersey's
exclusive BCBSNJ representative:

Medical Society of New Jersey
MSNJ

Jennifer Altobelli
Sales Representative
973-338-0893

39 Commentary

Two thousand year-old bug

By Lauren B. Eder, PhD

The computer date will soon change to January 1, 2000. Business continues as usual—if you are fully prepared.

43 Current trends

SAD: Shedding light on seasonal affective disorder

By Robin K. Levinson

When otherwise healthy patients feel sluggish, depressed, stressed, or irritated, think about seasonal affective disorder and the way to treat these patients.

47 Computer.med

Nursing the computer

By Eric J. Lerner

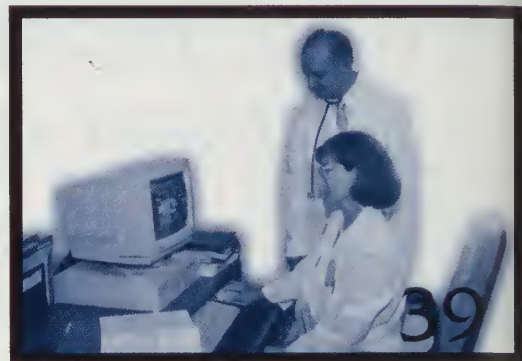
Nurses are using computers just like they use paper charts. Computers are increasing efficiency and productivity for nurses.

51 Special report

Preventing breaks: Osteoporosis and BMD measurement

By Julie Kelter Timins, MD

Osteoporosis is highly prevalent. Preventable measures include: estrogen hormone replacement therapy (HRT), diet, and exercise.



With less than two years to go, it is imperative to check far year 2000 compliance.

DEPARTMENTS

1 Newswatch

AMA lobbying efforts. Gatekeeper model. Risk sharing. HMO consolidation.

10 Mail Stop

Infertility costs in our own home state. Herb's herbs makes for good reading.

13 Editor's Notes

Alternative medicine and the Internet, a rich, albeit precarious, source.

16 F.Y.I.

World AIDS day. Sign your site. Best books. Getting there faster. People in the news.

20 Online @ MSNJ

Ride the web wave. We've got weather. Message madness. New to the neighborhood.

57 Calendar

Current listing of medical meetings and conferences around the state in the fall and winter.

60 Editorial Guidelines

Author information is available for the preparation of materials, including specifications and copyright.

64 Photo Finish

The importance of computerized digital imaging to diagnose coronary disease.



Stuart M. Hochron, M.D., Esq.

Physician Legal Representation

- Group Practice Formation
- Physician Litigation
- Federal Regulation
- Board of Medical Examiners

Practicing Physician, Twenty Years

Clinical Professor, UMDNJ-RWJMS

Research as Highlighted on CNN

AMA Physician Referral Service

Partner, Richmond, Hochron & Burns



phone: (732) 821-0200 fax: (732) 422-9444 e-mail: MDLAWSMH@aol.com

209 North Center Drive North Brunswick, New Jersey 08902

Infertility costs

Good medicine is costly, as is the kind of research that propels us into the next century. The insurance crisis of the past several years affects colleagues in all specialties, e.g. cardiology and oncology, where advanced diagnostics and treatments can dramatically alter prognoses and save lives. Our own experience shows that when insurers recognize that these developments actually are more cost effective over time, they have altered policy, and are willing to work with the reproductive medicine community, taking on all or partial payment of treatment previously judged experimental or non-essential.

In contrast to previous generations, urged to accept fate or adopt, today's couples can enter treatment with the increasingly valid hope that they will become parents. The days of secrecy and embarrassment, for the most part, are gone. Where early days of infertility treatment offered limited female surgeries and in vitro fertilization, today's knowledgeable couples are privy to a spectrum of therapies that offers more hope and much more success. Recognizing that almost one-half of all failures to achieve pregnancy are caused by male factor infertility, there has been an appropriate emphasis placed

on treating both males and females at major infertility centers.

Patients come to infertility specialists armed with information—from other physicians, friends, family, scientific papers, and the Internet. Thanks to our own ongoing research as well as cooperative research among colleagues, we can offer help where it has never been offered before: to patients with Swyer's syndrome, to men whose sperm are immature, and to young women and women in their later childbearing years who receive donor eggs. Egg donors, although financially compensated more highly now as Bill Berlin reports (*New Jersey Medicine*, August 1998), should still be viewed as altruistic because they subject themselves to temporary physiologic changes through hormonal intervention and intensive monitoring that require diligent visits to the involved infertility centers or satellite reproductive medicine specialists.

Good medicine requires consideration for outcome while respecting ethical, religious, and legislative guidelines. Through the ages, as Berlin points out, reproduction has been thought of as a right. If we, by educating those whose patients pay to assist them with medical financing, can continue to give hope and success through revolutionary treatments to infertile couples, we can combat the stereotype of these treatments as elitist and unnecessary.

Matan Yemini, MD

Arie Birkenfeld, MD

*Diamond Institute for Infertility
and Menopause*

Herb's herbs

I have just finished reading your article on "Herbs" in the Editor's Notes (August 1998). I feel this editorial is both timely and informative in view of the botanical cult currently captivating the American public.

I think that it would be very important to have regular contributions to *New Jersey Medicine* regarding the efficacy and safety of any of the currently used herbs and botanicals.

Thank you, again, for this stimulating article.

Earl Di Pirro, MD

Teaneck

Requirements for letters

To submit a letter, fax (609.896.1368), e-mail (info@msnj.org), or mail your letter to New Jersey Medicine, Two Princess Road, Lawrenceville NJ 08648. Letters should be typed and double-spaced and should be no longer than 400 words with 4 references, if necessary. Include your full name, affiliation, address, and telephone number.

Letters are published at the discretion of the editor-in-chief and are subject to editing and abridgement. Letters may be published on MSNJ's web site, <http://www.msnj.org>. Financial associations or other possible conflicts of interest must be disclosed. Letters represent the opinions of the authors.

Whether it's an alcohol or drug problem, count on Sunrise House for expert help.

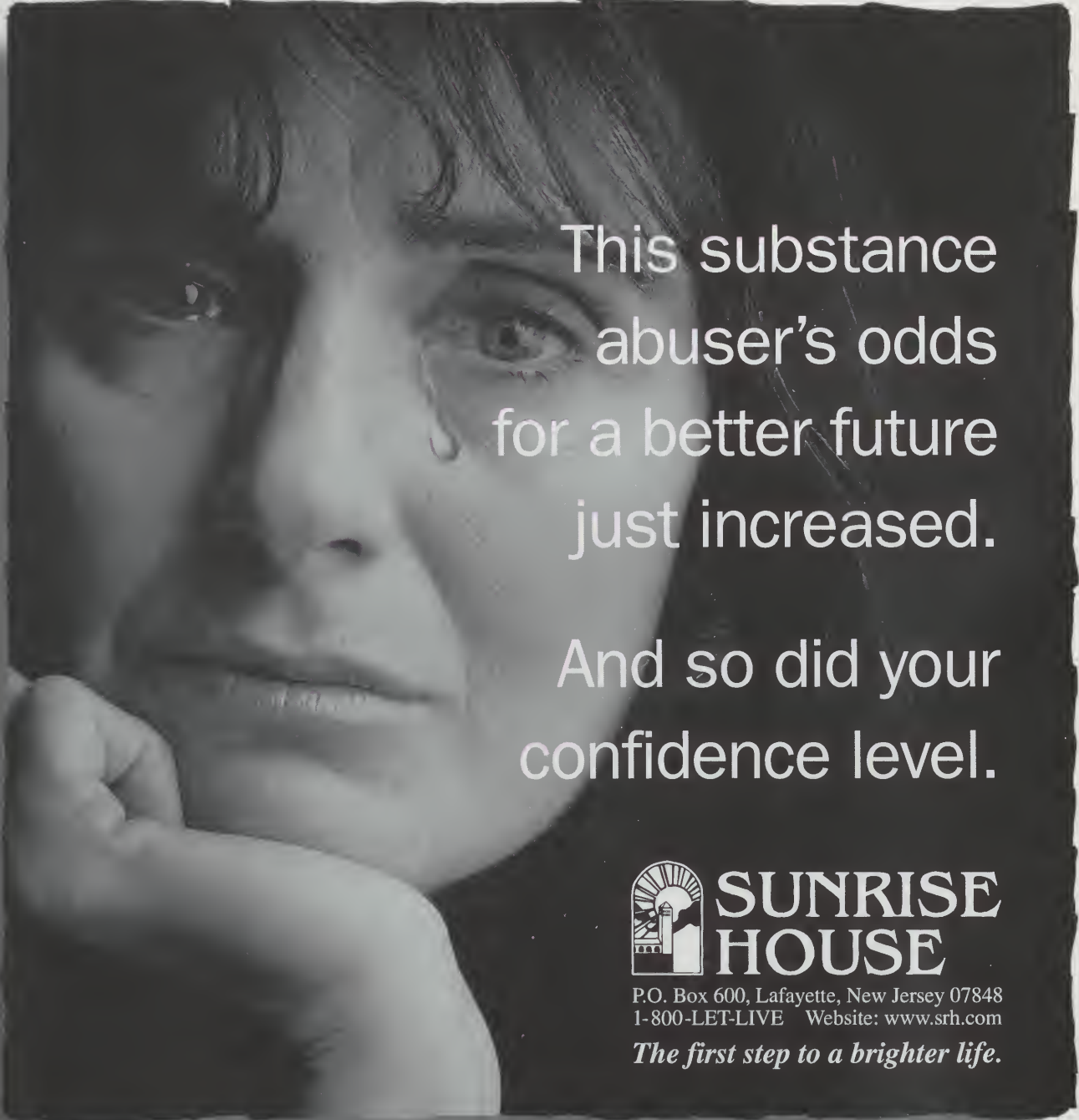
For 14 years, hundreds of tri-state area doctors have trusted us to offer their patients the most effective, caring treatment and a chance for a better life.

Set in the scenic hills of northwest New Jersey, we're a licensed, nonprofit specialty hospital with a nationally known commitment to quality—including Accreditation with Commendation by the JCAHO.

Our comprehensive programs include inpatient and outpatient services, after-care and family support.

And our experienced staff of doctors and specialists works closely with referring physicians to ensure continuity of care at every stage of treatment.

Sunrise House. High-quality, affordable treatment you can trust. For information, call us at 1-800-LET-LIVE or (973) 383-6300.



This substance
abuser's odds
for a better future
just increased.

And so did your
confidence level.



**SUNRISE
HOUSE**

P.O. Box 600, Lafayette, New Jersey 07848
1-800-LET-LIVE Website: www.srh.com

The first step to a brighter life.

Sunrise House is a preferred provider of most major insurance companies and HMOs.
We will process insurance benefits verification and precertification.

Our doctors aren't just great. They're the best.



Hudson County's best doctors practice at St. Mary Hospital of Hoboken and St. Francis Hospital of Jersey City. With nearly 600 skilled, caring professionals, our medical staff includes a growing number of leading specialists who are nationally-recognized experts in fields like perinatology, internal medicine and psychiatry.

So when you're looking for
a doctor, choose the best.
Call (201) 418-2020.

**ST. FRANCIS
HOSPITAL**
of Jersey City

**ST. MARY
HOSPITAL**
of Hoboken

The best doctors and nurses. Right in your neighborhood.™

Alternative medicine and the Internet

Robert Goldstone, MD, criticizes my editorial comments (August 1998) concerning Internet usage. He writes: "Your suggestion that the Internet, instead, should be a prime source of the basics, is to suggest that this completely unfettered electronic forum might disseminate more truth than our country's most prestigious peer-reviewed journals. While I delight in the pleasure of surfing the net, I cannot take this suggestion seriously. Surfing will help us to understand what others are saying about us, and what others believe, but at least in its present form, it cannot be taken as a substitute for genuine research and for perusing established journals in our field of interest. Since we are talking, however, about alternative medicine, and since we are questioning some of its claims, your readers might well be referred to such web sites as www.quackwatch.com and www.ness.com (The New England Skeptical Society). Too many of

us don't know how to answer the improbable and often irrational questions patients put to us about alternative practices, and these sites offer useful explanations and rebuttals."

Although I cannot find any area in my editorial where I suggested that surfing is a proper substitute for genuine research, Goldstone touches on genuine concerns about information displayed for both

physician and patient on the world wide web.

An editorial in the *New England Journal of Medicine* (*N Engl J Med*) of September 17, 1998, is entitled, "The Risks of Untested and Unregulated Remedies." In it, Angell and Kassirer note, "What sets alternative medicine apart, in our view, is that it has not been scientifically tested and its advocates largely deny the need for such testing." They point out that anecdotal reports in conventional medicine require proper trials before acceptance, but similar reports about alternative treatments are accepted on face value. That must change, say they.

An editorial in the *Journal of the American Medical Association* (*JAMA*) of April 16, 1997, subtitled "Caveat Lector et Viewor—Let the Reader and Viewer Beware," begins with "Health care professionals and patients alike should view with equal parts delight and concern the exponential growth of the Internet. . . . The problem is not too little information but too much, vast chunks of it incomplete, misleading, or inaccurate, and not only in the medical arena."

Howard D. Slobodien, MD



**The scientific mind does
not so much provide
the right answers
as the right questions.**

Claude Lévi-Strauss,

The Raw and the Cooked, 1964

Editor's Notes

Jadad and Gagliardi, in *JAMA* dated February 25, 1998, state: "Many incompletely developed instruments to evaluate health information exist on the Internet. It is unclear, however, whether they should exist in the first place, whether they measure what they claim to measure, or whether they lead to do more harm than good."

Warnings also have been given about some medical services given by physicians to patients on the web. No visual contact is made. The patient is contacted electronically, completes an electronic questionnaire, has an electronic consultation, and is given treatment, including medications, electronically. The practitioners—I hate to call them physicians—recommend this approach, not just for minor complaints, but also for emergency care, although they also advise personal contact with a live physician. If we agree that this is the proper practice of medicine, how can we resist the importuning of PAs, NPs, PTs, and ETCs?

Despite this litany of real and potential abuses on the Internet, it not only has value, it is an increasingly important aspect of our lives and must be appreciated. What I stated in the past is, "We should become familiar with the basics [about alternative and complementary methods], and the Internet is a

**To err is human,
but to really
foul things
up requires
a computer.**

Anonymous, in BBC radio program,

Quote Unquote, 1982

prime source." The *N Engl J Med* and *JAMA* are both on the Internet and deserve our attention, but other areas are better sources of the basics—identifying and trying to understand the many divisions and subdivisions of nontraditional care. Even Goldstone recommends two sites.

All scientific, or purportedly scientific, information deserves critical appraisal, whether on the world wide web or elsewhere. Unfortunately, the public, including physicians, must act as its own watchdog; Congress has abdicated its responsibilities. There are many reputable Internet locations: The National Institutes of Health, departments of the New Jersey state government, the National Institute of Medicine, and many scientific organizations and publications occupy favorite positions on my list of URLs. But even information derived from these fountainheads needs careful scrutiny.

So what guidelines can we follow? Although a proper scientific approach to alternative and complementary medicine probably requires a repeal of the 1994 Dietary Supplement Health Education Act, much worthwhile information can be obtained from both foreign and domestic sources.

The April 1997 *JAMA* editorial urges the electronic world to adhere to quality principles of the print world, "built on a foundation of accountability." Their core standards include proper identification of authors, references and sources; dates of performance; and disclosure—that "web site 'ownership' should be prominently and fully disclosed, as should any sponsorship, advertising, underwriting, commercial funding arrangements or support, or potential conflicts of interest," including tie-ins to other sites.

We should encourage these actions. Even if followed, difficulties will remain. Many get (mis)information from television and other uncontrolled sources. Anecdotal cases are presented as real breakthroughs, and the public swallows it whole. At least we, as professionals, can try to learn about current trends, in order to give accurate information to our patients. The Internet is a rich, albeit precarious, source.

Ever wish your broker, your trust officer
and your banker had more in common?



A single vision of your future, for example?

As a physician, you spend a lot of time serving your patients and managing your practice. Where do you find the time to manage the people who manage your financial affairs? At PNC Private Bank, the team of people that manage your financial affairs can be just that: a team. People who work together, with a common goal: to realize your vision of the future. PNC Private Bank brings together under

one roof every service you need, backed by 150 years of professional money management experience and the resources of one of the country's largest financial institutions. No conflicts of interest. No misinterpretations. Just the synergy that can only come when everyone who works with you works with each other as well. Call 1-888-844-1565 to learn more about the difference at PNC Private Bank.

PNC PRIVATE BANKSM

Visit us on the World Wide Web. Our address is <http://www.pncbank.com>

Investments • Trusts • Banking Services

PNC Private Bank is a service mark of PNC Bank Corp. Banking and trust services are provided: by PNC Bank, National Association in Pennsylvania, New Jersey, Kentucky, Ohio and Indiana; by PNC Bank, New England in Massachusetts and Connecticut; by PNC Bank, Delaware in Delaware; and by PNC Bank, FSB in Florida. Members FDIC. Brokerage services are offered through PNC Brokerage Corp, a registered broker-dealer and member SIPC. PNC Brokerage Corp is a subsidiary of PNC Bank, National Association, which is not a broker-dealer.

SIGN YOUR SITE

The American Academy of Orthopaedic Surgeons has launched "Sign Your Site," a national education program to encourage surgeons and other health care providers to implement controls to eliminate wrong-site surgery. The Academy's Advisory Statement on Wrong-Site Surgery recommends the operating surgeon discuss the surgery with the patient before anesthesia, place initials on the operative site using a permanent marking pen, and operate through or adjacent to initials. The Advisory Statement also includes recommendations for specific actions if the surgeon discovers that he or she is performing or has performed wrong-site surgery. For information call Emily Kattke at 847.384.4126.

CENTENARIAN STUDY

Harvard Medical School and the Beth Israel Deaconess Medical Center, both in Boston, are seeking participants for a genetic study on aging to discover information that could lead to a cure for diseases like Alzheimer's and cancer. Subject candidates are individuals 98 years and older and their living brothers and sisters who are at least 90 years old. Participants do not have to reside in the Boston area. For information, call 1.888.333.6327.



BEST BOOKS

Doctors looking for authoritative, reliable health information for patients can turn to four new guides on asthma, menopause, hypertension, and depression. Contact the AMA at 312.464.4430.

WORLD AIDS DAY

Individuals, organizations, and families across the Garden State and the world will participate in World AIDS Day on December 1 to promote messages of compassion, hope, and understanding about AIDS. This year's theme is "Force for Change: World AIDS Campaign with Young People." The best way to stop the spread of HIV, says New Jersey Department of Health and Senior Services (DHSS) Commissioner Len Fishman, is through education, which will enable individuals to use this information in a positive manner. DHSS is sponsoring programs to promote World AIDS Day. A symposium entitled, "The AIDS Epidemic: New Jersey and Beyond," will be held on December 1. In keeping with this year's theme, DHSS is hosting "World AIDS Day of Learning for New Jersey Youth," on December 2, where students will learn about HIV transmission and high-risk behavior in an interactive, "teens teaching teens" approach to education.

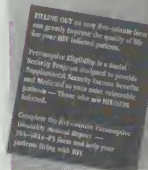


Commissioner
Len Fishman

PRESUMPTIVE ELIGIBILITY PROJECT

In an outreach program effort, the Community Health Law Project has published a brochure for physicians. The brochure offers information to improve the quality of life for patients living with HIV. By completing a social security benefits form, physicians can help patients receive presumptive disability benefits, which provide cash benefits and Medicaid to persons with pending claims. Endorsed by DHHS, patients can receive access to care earlier than at the present time. Brochures are available by calling 973.275.1175.

How can you
improve the
quality of life
for your
patients living
with HIV?



GETTING THERE FASTER

These days paramedics at Saint Barnabas Health Care System use motorcycles to respond—in many instances more quickly than conventional ways—to emergency medical care. "Our Motorcycle Paramedic Team strengthens the scope of the emergency medical services Saint Barnabas provides," says Ronald J. Del Mauro, president and CEO of Saint Barnabas



Fabrizio Bivona (left) and Jeff Goldstein are members of the Saint Barnabas Health Care System Motorcycle Paramedic Team.

Health Care System. In cooperation with local law enforcement, the Saint Barnabas Motorcycle Paramedic Team also will develop programs that promote motorcycle safety. Saint Barnabas is the first hospital system in the nation to offer this innovation.

THE RIGHT PRESCRIPTION FOR YOUR CALLERS



Message-On-Hold Systems

Use your telephone music-on-hold feature to:

- 📞 Promote Services
- 📞 Reassure Callers
- 📞 Educate & Inform
- 📞 Encourage Referrals

ORDER ONLINE

PATIENTS ON HOLD LIBRARIES

complete package for **Only \$495**
go to www.holdcom.com/libraries

HOLDCOM

Serving the NJ Healthcare Industry Since 1987

Call 1-800-666-6465
www.holdcom.com

You take care of your patients. We'll take care of the health of your practice. Our group of health care accounting specialists provides the medical community with the right type of analysis and counseling to be successful.

Since we're dedicated to increasing your profitability, never simply reporting it, we'll see

to it that your practice stays healthy for many years to come. To experience our unique approach, please call Ira S. Rosenbloom, Managing Director, at 973-882-1100.

PRACTICE GOOD FINANCIAL MEDICINE.



Mintz Rosenfeld & Company LLC

Profitability Consultants • Certified Public Accountants

60 Route 46 East, Fairfield, NJ 07004
Tel: 973-882-1100 Fax: 973-882-1560

OUR FOCUS IS YOUR SUCCESS.

NEW JERSEY RESIDENTS: DOUBLE-TAX-FREE INCOME

**100% NO
LOAD**

**YIELDS
7.28%**

Tax-equivalent
36% tax rate

4.36%

Current
30-day yield
as of 9/27/98

T. Rowe Price New Jersey Tax-Free Bond Fund is ranked #2 out of 16 funds in the Lipper New Jersey Municipal Debt Category since its inception (4/30/91) for the period ending 9/30/98.* This fund invests primarily in long-term New Jersey municipal securities, so the income it offers is double-tax-free. *You pay no state or federal tax on your investment earnings.*** Proprietary credit analysis and active management help reduce risk. Of course, the fund's yield and share price will fluctuate as interest rates change.

With no sales charges, all your money works for you. The fund is 100% no load. And, since there are no broker fees—which can eat up as much as 5% of your principal—all your money gets invested. \$2,500 minimum. Free checkwriting.†

**Call 24 hours for your
free investment kit
including a prospectus**

1-800-541-4532
www.troweprice.com

Invest With Confidence®
T. Rowe Price



9.14%, 5.78%, and 8.06% are the fund's 1-year, 5-year, and since inception (4/30/91) average annual total returns, respectively, for the periods ended 9/30/98. Figures include changes in principal value, reinvested dividends, and capital gain distributions. Investment return and principal value will vary, and shares may be worth more or less at redemption than at original purchase. *According to Lipper Analytical Services, Inc., which ranked T. Rowe Price New Jersey Tax-Free Bond Fund #7 out of 58 for the 1-year period ended 9/30/98. **Some income may be subject to the federal alternative minimum tax. Income earned by non-New Jersey residents will be subject to applicable state and local taxes. †\$500 minimum. Past performance cannot guarantee future results.

Read the prospectus carefully before investing. T. Rowe Price Investment Services, Inc., Distributor.

NJB044864

PEOPLE IN THE NEWS

Sara A. Liptak, RN, MSN, is the new president of the New Jersey State Nurses Association.



Sara A. Liptak, RN, MSN

MSNJ members Mark Olesnick, MD, and Anthony P. Caggiano, Jr, MD, were presented with the Distinguished Health Care Service Award by the Essex Council, Boy Scouts of America.

Bernard D. Goldstein, MD, a member of MSNJ and one of the nation's leading medical authorities on the environment and public



Bernard D. Goldstein, MD

health, is the acting dean of UMDNJ-School of Public Health.

Bergen Regional Medical Center announces that MSNJ

member Michael Nevins, MD, has been named vice-president of medical affairs.



Michael Nevins, MD

MSNJ member Philip L. Lebovitz, MD, has assumed the office of president of the Capital Health System medical staff.

The Oncology Society of New Jersey installed MSNJ member Andrew I. Zablow, MD, as its new president.

HIGH-RISK PATIENTS

Diabetics are about three times more likely to die from complications of the flu and pneumonia, yet less than one-half of the diabetics get a flu shot, says the CDC. Each year 10,000 to 30,000 diabetics die from complications of the flu and pneumonia. The CDC recommends that people with diabetes get a vaccination. Other at-risk individuals also should receive vaccinations. Contact Lisa Hibbs (609.896.1766) for information.

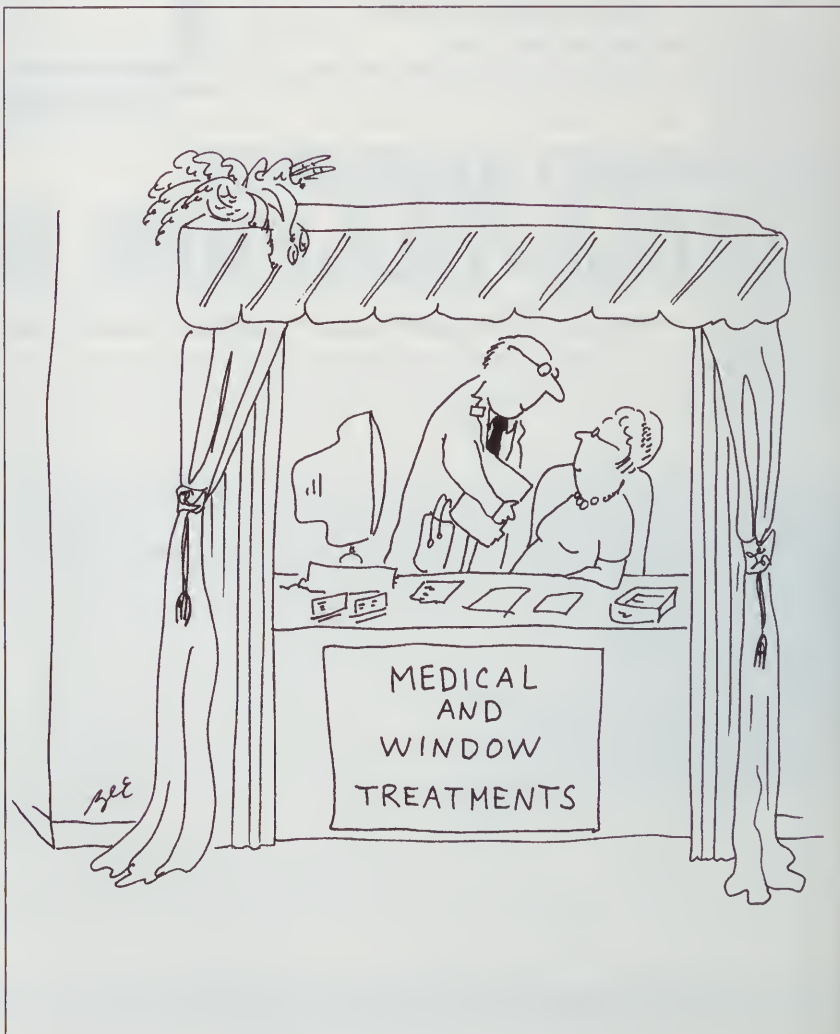


TOP DOC

MSNJ member Robert M. Arbour, MD, has been selected as Physician of the Year by the medical staff at Bayshore Community Hospital. He is a diplomat of the American Board of Surgery and a fellow of the American College of Surgeons. A resident of Little Silver, Arbour has served as director of surgery at Bayshore Community Hospital. He holds memberships in the Monmouth County Medical and the Monmouth Surgical Societies.



Robert M. Arbour, MD



THE SIGN OF GREAT COVERAGE.

WHEN IT COMES TO FINDING PROFESSIONAL LIABILITY INSURANCE, ALL ROADS LEAD TO GULF ATLANTIC

The need for comprehensive professional liability insurance has never been greater. And with so many new companies sprouting up almost daily, finding the right plan isn't getting any easier. That's why the Gulf Atlantic Professional Liability Program might be the protection you need, and have been looking for.

For over twenty years Gulf Atlantic has been successfully providing insurance protection for the medical community. And since Gulf Atlantic policies are underwritten by Clarendon National Insurance Company, your coverage comes with an **A.M. Best A- (Excellent) rating**.

So while other carriers dot the landscape and attempt to block your view, Gulf Atlantic will help you navigate through the many choices by providing a program designed specifically for your needs.

For more information on how you can arrive at your destination safely, contact **The Stewart Group, 107-A Corporate Blvd., South Plainfield, NJ 07080, (908) 755-0066**.

UNDERWRITTEN BY



The Gulf Atlantic Professional Liability Program is Underwritten by Clarendon National Insurance Company which has an **A.M. Best A- (Excellent) rating**.



The Gulf Atlantic Professional Liability Program

GULF ATLANTIC INSURANCE SERVICES, INC.

General Agent

1-800-739-4242

RIDE THE WEB WAVE

It seems that everyone has a web site. If you're looking to establish a presence on the web, keep in mind some basic aspects to creating a web site. *Marketing.* The "look

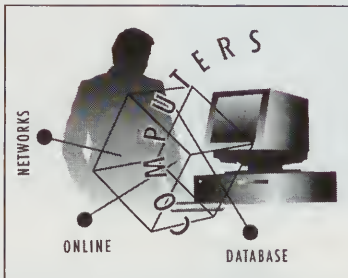


and feel" of your web site. *Production.* Gathering the infor-

mation for your web site and formatting the data for the end-user. *Programming.* Using hypertext markup language (HTML), the Internet formatting language, which is embedded in documents for viewing. *Server management.* You need to know your server—the hardware that houses data that will be viewed on the Internet.

WE'VE GOT WEATHER

Through wind, rain, hail, or sunshine, if you need to know the most up-to-date forecast, turn to weather on the world wide web. From www.accuweather.com to www.weatherimages.org or www.nws.noaa.gov/, these sites offer weather reports on present and upcoming conditions. You can't leave home without it, or at least take an umbrella!



MESSAGE MADNESS

Ever wonder what those annoying Internet connection messages really mean? Here's some insight. *The server does not have a DNS entry.* Your Internet provider cannot find the numeric web equivalent, based on the web address you typed. *The spinning hourglass (or beach ball).* Be patient, a connection is being made. *404-Not found.* Cannot locate the exact web page you requested. *503-Service unavailable.* Site overload; too many people are trying to get onto the site. *401-Unauthorized and 403-Forbidden.* You didn't enter a password or entered it incorrectly or the site requires special permission to access.

NEW TO THE NEIGHBORHOOD

If you're just delving into cyberspace, it can be daunting. So do your homework. Check out these primers that will help you understand the Internet and how it works: Learn the Net (www.learnthenet.com/english/index.html), Cyber Course (www.newbie.net/CyberCourse/), and Travis County Medical Society Internet Primer (www.tcms.com/primer.html).

BOOKMARKS

www.diabetes.org/adanj

November is National Diabetes Month. Learn more about diabetes from the American Diabetes Association, New Jersey Chapter. Also check out the web site of LifeScan, the makers of blood glucose monitoring systems for diabetes at www.LifeScan.com.

www.bigv.com

At Viagra® Talk, clinicians can get guidance on prescribing Viagra®, including side effects and patient and physician experiences with the drug.

www.e-cards.com

Send free animated electronic greeting cards for special occasions and celebrations (also at Blue Mountain Arts web site, www.bluemountain.com)

www.technologynj.org

Find solutions to the year 2000 computer problem at the non-profit association, Technology New Jersey, Inc.

www.operationsmile.org

Learn more about Operation Smile, a national medical service organization, and its many medical volunteers.

John Paul Dizzia, P.C. ATTORNEYS AT LAW

Legal Counseling and Representation to Medical Professionals in administrative, regulatory and disciplinary matters before the State Board of Medical Examiners, the Department of Insurance, the Division of Medical Assistance and Health Services, and in the law relating to professional rights, responsibilities, ethics and practice issues.

Member:

- National Health Lawyers Association
- Health and Hospital Law Section,
New Jersey Bar Association
- New Jersey Association of
Professional Mediators

108 North Union Ave.
P.O. Box 886
Cranford, N.J. 07016

Call: (908) 276-6111
FAX: (908) 276-5838
E-mail: JPDLEGAL@AOL.COM

The Medical Manager[®] Practice Management Software

A fully integrated practice management solution

Over 16 years' experience in providing
healthcare automation solutions

Provides an open system architecture
and flexibility for specialized needs

Designed for small group practices to large
Integrated Delivery Systems

Overwhelming national presence

*Learn more about how Medical Manager Corporation and
The Medical Manager system can meet your needs. Contact us
at 800.677.7784, 201.808.0088, or www.medicalmanager.com.*

Medical Manager

Corporation
RTI, Inc. and Medix

Empowering the Industry Through Partnership



Excel Business Park
501 Prospect Street

Unit 96

Lakewood, NJ 08701

Phone: 732•886•0600

Fax: 732•886•0911

"The overall effect is total customer satisfaction."

- Medical/Dental Cabinetry
- Nurses Stations
- Reception Desks
- Nourishment Centers
- Medical/Dental
Procedure Carts
- Computer Desks
- Monitor Cabinets
- Chart Racks
- Corian[®] Solid Surfacing
Certified Fabricator #C-5112
- Space Planning/Layout

N

EW JERSEY PHYSICIANS AND HEALTH CARE WORKERS GIVE TIME
AND SERVICES TO HELP MEDICALLY UNDERSERVED CHILDREN BOTH
HERE AND ABROAD. THEY'RE VOLUNTEERS WITH THE NATIONAL
MEDICAL SERVICE ORGANIZATION, OPERATION SMILE.

MEDICAL VOLUNTEERS MAKE GLOBAL IMPACT

Nancy M. Profsner

"In Kenya, I put in long, grueling days with very few breaks—double my usual workload. It was challenging, but the return is unbelievable. I was so charged and motivated by the moment—by what I was experiencing and seeing." This is how Whitehouse Station resident Elizabeth Grose, RN, a nurse at Saint Peter's University Hospital, describes her Operation Smile medical mission to Kenya as a volunteer, where she hopes to return.

team's daily surgical schedule for the operating room. Operation Smile brought over the technical equipment, which the medical team had to rig up to the local equipment at Nakuru's time-worn Rift Valley Provincial General Hospital. The last renovation the hospital had seen was back in the 1940s. Grose and the team of experts operated on over 150 patients, repairing cleft lips and palates and releasing burn scars.

Grose's main responsibility in Kenya was to coordinate the medical missions to 18 countries including Philippines, China, and Russia, pro-



Operation Smile volunteer takes a moment to comfort a young patient.

viding \$28 million of free medical services. This national medical service organization, founded in 1982 by plastic surgeon William P. Magee, Jr, MD, DDS, and his wife, Kathleen, a nurse and clinical social worker, both who grew up in Fort Lee, provides free reconstructive surgery for needy infants, children, and teenagers. The medical teams repair debilitating cleft lips and palates, remove tumors, correct congenital hand deformities, and mend severe facial and body burns.

To the tune of \$150,000—and months of precise planning and coordination—a volunteer medical team from around the world and medical supplies and equipment will assemble at a single hospital in an underserved country. Because they cannot rely on adequate medical supplies from the mission

country, every item—from Band-Aids® to anesthesia equipment—will be brought over. "Many Vietnamese hospitals don't even have basic equipment like CAT scans and MRIs," says MSNJ member Arthur

Brown, MD, head of the Division of Plastic and Reconstructive Surgery, Cooper Hospital University Medical Center. "I've gone to numerous regions in Vietnam and many of the Vietnamese doctors and nurses have never seen or done these reconstructive procedures. So it's a teaching opportunity, too." The Kenyan doctors and nurses, agrees Grose, are eager to learn state-of-the-art techniques. Brown, also a professor of surgery and pediatrics at UMDNJ-Robert

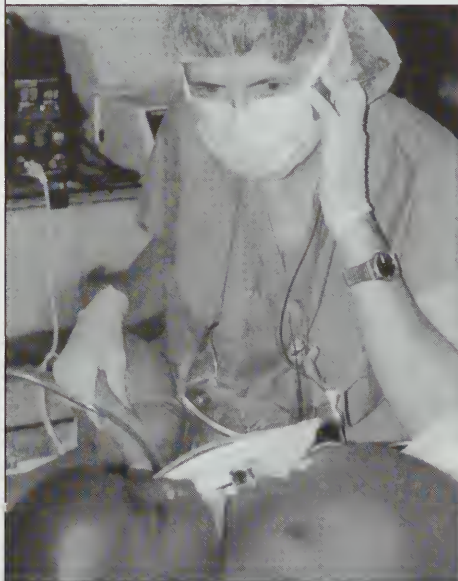
Wood Johnson Medical School, Camden, has been returning yearly to Vietnam; his first trip was in 1989. "I have a strong desire to return to Vietnam to finish the uncompleted work," says Brown.

Brown values the professional bond he's established with many of the Vietnamese doctors and nurses who share Operation Smile's vision. "We correspond regularly. I send them medical journals and other health care information."

"We couldn't make it without the longstanding commitment of New Jersey companies like Nassau Communications, Bristol Myers-Squibb, Warner-Lambert, and Becton Dickinson," says DeLois Greenwood, Operation Smile director of strategic partnerships. Johnson & Johnson contributes \$1.2 million worth of medical supplies each year. Likewise, Ethicon provides sutures free of charge.

Even with the vast donations of medical supplies, organizers realize that the true difficulty lies in the number of needy children. "We have to turn away hundreds of children. That's the toughest part," says Brown.

A nurse volunteering with Operation Smile monitors a young patient.



"We have to send them back to their villages, their hopes dashed." Many have endured tedious days of travel, usually on foot, to reach a hospital. The inadequate transportation infrastructure in developing countries, reminds Brown, isolates most villagers from medical care in the cities. For a few select children, these doctors and nurses are saviors.

But it's not just overseas where medical care is lacking. Across America there is an abundance of

uninsured children; in our state the number stands at 375,000. Operation Smile has cared for thousands of American children, relying on volunteer surgeons to perform operations stateside. This program—the Domestic Medical Pro-



Operation Smile volunteers check a patient after surgery.

gram, headquartered in New Brunswick—identifies, evaluates, and assesses children in urban and rural areas throughout the United States.

Newark joins the Domestic Medical Program in a partnership with the University of Medicine and Dentistry of New Jersey (UMDNJ) and the Newark pub-

lic school system. With the help of school nurses and clinicians, UMDNJ medical students identify children in the school system in need of surgical assistance. The children then receive medical attention from volunteer physicians.

Patterned after a successful New York City program, the UMDNJ alliance fills a huge gap in medical care, especially with the growing Garden State urban immigrant population. "These people don't know how to access our health system," says Stephen O'Connor, Operation Smile board member and president of New Brunswick Tomorrow. "Unfortunately, there are lots of

children without medical coverage. Plus many insurance companies won't cover these operations because they're categorized as purely cosmetic surgery."

With the new millennium in sight, countries continue to struggle with the staggering population of underserved infants and children. Operation Smile provides global impact, but it's not enough. Two out of three patients seeking medical attention are turned away. "Through training of native surgeons, we'll one day reach the point where they'll perform these operations without us," says Brown. That's Operation Smile's ultimate goal.

Changing the Future

Family practice resident Jill Gora, MD, experienced medicine at its most primitive during her Operation Smile medical mission to Mindanao, an island in the Philippines. The operating room was bare except for a light hanging in the middle of the room and a rack in the corner drying latex gloves that would be reused. The volunteer team had to construct makeshift operating tables. The pharmacy consisted of a cabinet. Post-op was overcrowded with cots lined up only inches apart. The families had to bring their own food and sheets.

Yet, there was a warm welcome by the hospital staff. They were gracious and happy to work along side the Operation Smile medical team. And it was tough work: infectious disease is always a risk, clean water isn't readily available; there are no emission standards in the cities, so polluted air is a problem.

"The time I spent in Mindanao is priceless," says Gora, who also founded the state's first Operation Smile medical school chapter at UMDNJ. "To be able to change an underserved child's future with a relatively easy procedure is truly amazing."

DIVORCE

If "sophisticated" describes your lifestyle, it should also describe your legal representation.

It just makes sense.

When facing divorce, the law firm you choose should have the experience and resources to obtain maximum results.

Our Family Law Department has knowledgeable attorneys with in-depth experience handling complex and substantial situations. We also have a strong reputation for success, complete support resources and access to our firm's other legal departments. So, no matter where a case may lead, the client is effectively represented.

If "sophisticated" describes your lifestyle *before* a divorce, it should also describe your lifestyle *after* a divorce.

Free helpful information

For copies of our popular "Divorce and Child Custody: Frequently Asked Questions" and "Choosing a Matrimonial Lawyer", call (732) 855-6400.

MATRIMONIAL & FAMILY LAW / DIVORCE MEDIATION

divorce / custody / separation / annulment / prenuptial agreements / modification & enforcement of judgments / palimony / adoption / visitation



**WILENTZ
GOLDMAN
& SPITZEL**

ATTORNEYS AT LAW

A PROFESSIONAL CORPORATION

Two Industrial Way West
Eatontown, New Jersey 07724
(732) 542-4500

90 Woodbridge Center Drive
Woodbridge, New Jersey 07095
(732) 636-8000

88 Pine Street
New York, New York 10005
(212) 267-3091

<http://www.newjerseylaw.com>

KNOCK KNOCK CONCUSSIONS FROM SPORTS INJURIES



EACH YEAR, 20 PERCENT OF THE 1.54 MILLION HEAD INJURIES IN THE UNITED STATES RESULT FROM PARTICIPATION IN SPORTING EVENTS.

THESE EVENTS SPAN THE VENUES OF SCHOOL-RELATED ACTIVITIES AND RECREATIONAL ATHLETIC LEAGUES THROUGH PROFESSIONAL SPORTS. WE

NEED TO EDUCATE PROFESSIONALS AND THE PUBLIC

WITH GUIDELINES FOR THE IDENTIFICATION AND MANAGEMENT OF SPORTS-RELATED CONCUSSION.

Rosemarie Scolaro Moser, PhD

The medical community has become enlightened to the seriousness of concussion and to the misunderstanding and myths shared by sports personnel, athletes, medical professionals, and the public regarding concussion identification and treatment. The danger lies in the fact that an alarming number of athletes, coaches, and trainers do not know how to correctly identify concussions and that many physicians are not properly trained in "return to play" decision making.

A brain that has suffered concussion is more vulnerable to repeated hits. Having sustained one concussion increases the risk four to six times of sustaining another concussion. The effects of concussion are cumulative over the span of an athlete's career and, multiple concussions may increase the risk of degenerative brain diseases such as Alzheimer's, cerebral atrophy, and Parkinsonian-like symptomatology.

The statistics are frightening: one in five high school football players sustains a concussion each year; 50 percent of college athletes have had a history of concussion; 11 percent of ice

hockey players, 17 percent of wrestlers, and 19 percent of baseball and softball players sustain concussions every season and 90 percent of boxers show neurological dysfunction. As the symptoms of concussion can be mild and insidious, often going unnoticed, it is likely that concussion is under-reported and that these statistics underestimate actual frequencies.

Cerebrospinal fluid acts as a shock absorber between the brain and the hard skull. But a swift, hard check to the body can result in the brain's brush against bony protuberances on the inside skull, as well as in the twisting of

Table 1. Summary description of grades of concussion.*

Grade	Severity	Symptoms
1	Mild	Confusion, no loss of consciousness A sense of feeling "dinged" Resolves in less than 15 minutes
2	Moderate	Confusion, any amount of amnesia No loss of consciousness Symptoms last more than 15 minutes
3	Severe	Any loss of consciousness Brief = loss of consciousness lasts for seconds Prolonged = loss of consciousness lasts for minutes

*Adapted from the American Academy of Neurology guidelines.

the brain, which is anchored at the brain stem. Diffuse axonal shearing occurs, which may not be detected by CT or MRI, often resulting in post-concussive symptoms. More severe injury, such as intracranial bleeding, subdural hematoma, and cerebral contusions, also may occur. However, in the absence of more severe injury, mild concussion promotes metabolic changes, which persist even after what may look like full recovery, thus increasing vulnerability to further damage. It is these metabolic changes due to repeated concussions that can cause dysfunction of the blood vessels and the cerebrovascular system. In the case where an athlete does

not fully recover from a concussion and then experiences a second concussion, usually within a week's time, second impact syndrome may occur. This rare condition often is fatal due to rapid cerebral swelling. It most often occurs in young athletes and in children under the age of 21 years. Careful concussion assessment and identification are imperative to help prevent brain

damage, post-concussion syndrome (PCS), and second impact syndrome. The American Academy of Neurology has published new guidelines identifying the different grades of concussion (Table 1).

Generally, concussion can be diagnosed in the individual who exhibits any alteration in mental status, disorientation or confusion, delayed responses, amnesia, loss of consciousness, slurred speech, or vacant stare. Examination may indicate fixed or unequal pupils, revealing clear neurological involvement. Other symptoms of concussion, which may not be immediately ascertained, include headache, dizziness, nausea or vomiting, memory, attention or concentration difficulties, slowness in information processing, fatigue, and visual disturbance. Guidelines also have been provided for return to play decisions (Table 2). Nevertheless, even with these guidelines, there are no firm,

scientifically validated criteria for return to play, so it is best to err on the side of safety. Furthermore, neurological and radiological procedures frequently are not sensitive to the effects of mild head injury, rendering medical diagnosis quite problematic.

Moser (right) and the players and coaches of the Lawrence Flames discuss helmet use before ice hockey practice.



Neuropsychological testing has proved to be more sensitive even to the subtle effects of a single mild concussion 24 hours post-injury. No athlete with any symptoms should return to play. Ultimately, the decision to return to play should be made by a team of individuals, which may include the physician, the athletic trainer, the coach, the player, the parent (in the case of minors), and the neuropsychologist.

The use of neuropsychological testing in professional athletes has become a standard that now is encouraged at the college and high school levels of play across the country.

Neuropsychological testing is being used in preseason baseline testing of young athletes to determine their standard levels of neuropsychological functioning. Baselines provide data against which to compare test results that are gathered post-injury. A full, comprehensive neuropsychological evaluation is performed on an athlete after an injury has been sustained to more thoroughly assess areas of possible dysfunction or damage and to devise a cognitive rehabilitation treatment plan.

Cognitive rehabilitation can be helpful especially in the treatment of

Table 2. Return-to-play decision guidelines.*

Return-to-same play: If a Grade 1 concussion, all symptoms resolve in less than 15 minutes, and no symptoms with physical exertion.

One-week absence: If a Grade 2 concussion, Grade 3-brief concussion, or multiple Grade 1 concussions.

Two-week absence: If a Grade 3-prolonged concussion, or for multiple Grade 2 concussions.

One month or longer absence: If multiple Grade 3 concussions.

*Adapted from McCrea, M, et al.: *The Standardized Assessment of Concussion*, Washington, DC, 1997.

post-traumatic brain injury or post-concussion syndrome (PCS). PCS is an insidious disorder that often is misdiagnosed, dismissed, ignored, or denied. The afflicted individual will present with what seems to be vague psychological complaints. There may be problems with thought processing (memory, attention, concentration, forgetfulness), changes in mood (irritability, anxiety, depression, frustration), and physical complaints (headaches, dizziness, fatigue). The longer the disorder remains untreated, the more difficult the recovery and adjustment. Treatment for PCS can include cognitive rehabilitation, biofeedback, psychotherapy, pharmacotherapy, relaxation training, and hypnosis.

Efforts to structure sideline assessment of concussion have resulted in a number of sideline

assessment tools, such as the Standardized Assessment of Concussion (SAC), which provides athletic trainers and others on the sidelines the opportunity to quickly screen for concussion in a structured, repeated way, assessing orientation, concentration, memory, and exertion.

In a sports-oriented society that promotes being tough on the field, playing through the injury, and not admitting to brain dysfunction, a Grade 1 or 2 concussion is anything but a "small head bonk." The denial of concussion in professional athletes is a grim event and in our youth is even more frightening. This denial begins early in youth sports and is reinforced by society and needs to be re-evaluated.

Dr. Moser is director, RSM Psychology Center, in Lawrenceville.

YOUR PRACTICE HAS CHANGED SIGNIFICANTLY. SO WHY HASN'T YOUR PRACTICE INSURANCE?

Traditional policies for medical practices are not tailored for you. In fact, the same insurance policy you currently use covers everything from a shoe store to a pizza parlor. Does that sound logical?

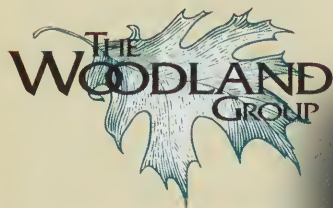
The Woodland Group has changed the concept of insuring a medical practice. Today, your medical practice can be protected by The Woodland Alliance Profile, a Risk Management Group created exclusively for physicians offering...

- Practice-specific coverage that has and will continue to evolve as the medical industry changes, covering everything from office property and patient charts to diagnostic equipment, general liability and workers' compensation.
- An opportunity to share in profitability of the Risk Management Group through profit sharing returns.

Put Yourself in the Hands of a Specialist.

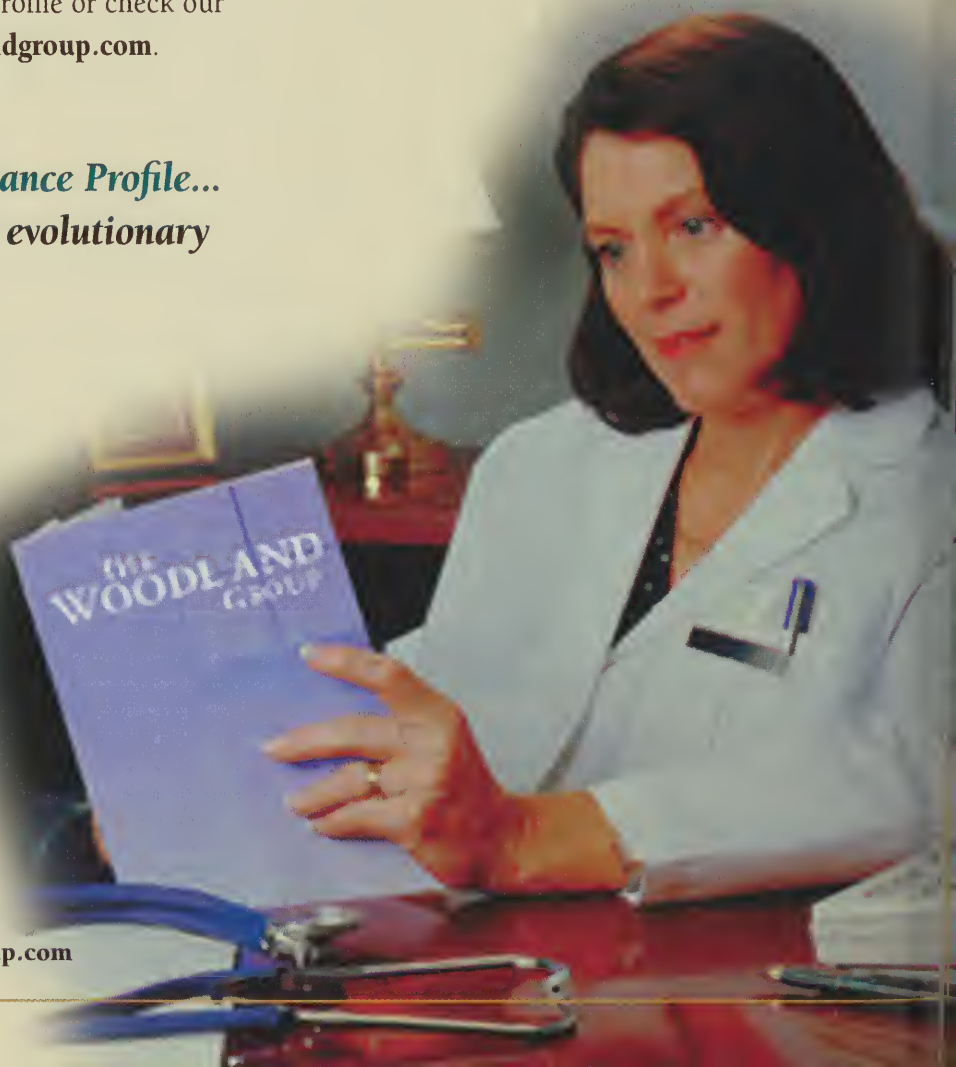
Call us at **1-800-253-1521** to learn more about The Woodland Alliance Profile or check our website at **www.woodlandgroup.com**.

The Woodland Alliance Profile...
coverage that is as evolutionary
as your practice.



- Medical Malpractice
- Managed Care Liability
- Group Disability
- Group Term Life
- Homeowners/
Automobile

1-800-253-1521
<http://www.woodlandgroup.com>



IMPOTENCE

AFTER RECOVERY FROM GUILLAIN-BARRÉ SYNDROME

FOR MEN RECOVERING FROM GUILLAIN-BARRÉ SYNDROME, THERE HAS BEEN A SIGNIFICANT INCREASE IN IMPOTENCE COMPARED TO THE GENERAL MALE POPULATION. THE CAUSE IS RELATED TO INCOMPLETE REPAIR OF AUTONOMIC NERVE FIBERS SUPPLYING THE PELVIC AREA AS PROVED IN A RECENT SURVEY OF ALMOST 400 MEN.

Kopel Burk, MD; Alan Weiss, PhD

Guillain-Barré syndrome (GBS) is a relatively rare paralytic neurological disease, affecting 1 to 2 people per 100,000 population yearly.¹⁻⁵ The mortality rate is between 1 and 5.6 percent.^{4,6} Recovery occurs in 85 percent of patients within 6 months, though improvement may continue for as long as 24 months.^{2,7} Less than 10 percent of patients are left with severe residual disabilities.^{2,7,8}

Only an occasional article mentions impotence in the current literature. Ropper's article in 1992 discussed the problem, suggesting that impotence following GBS most likely could be found in those men with severe dysautonomia and sensory loss during the acute phase of GBS, or in men suffering from depression.⁹

The current study was designed to learn what effect GBS had on impotence following recovery. If the inci-

dence of impotence was significant in our surveyed male population, we hoped to determine if the increased incidence correlated with the severity of the residual disability and whether depression or other medical conditions were contributing factors.

MATERIALS AND METHODS

With the help of the GBS Foundation International, 10,000 patients in the United States and England received a questionnaire. These surveys were distributed at GBS support group meetings, or through *The Communicator*, the Foundation's official publication from May 1994-June 1995. There were 847 replies; 27 were discarded because the gender of the respondent could not be identified; 4 were discarded because the questionnaires were partially filled out by a parent for a young child; 62

were discarded because they were received after the database had been entered into the computer. Of 754 usable replies, 396 were from men and 358 from women. This article concerns the 396 male respondents.

RESULTS

Table I displays the data concerning impotence in the surveyed population of 396 men. The incidence of impotence following recovery from GBS was 42 percent (166 of the 396 men). Prior to GBS, only 35 patients (8.8 percent) were impotent. Table I also compares our results with the Kinsey statistics.¹⁰

In the 20-40 year-old age group, 17 percent (11 of 66 men) reported problems with impotence following GBS. Prior to GBS, only 1 man (1 percent) reported erectile dysfunction. This difference is significant, $P=0.002$. In the Kinsey report, 10 of

513 men (1.9 percent) in the 20-40 year-old age group of the general population were impotent. The probability that our post-GBS group and the Kinsey population are statistically identical is remote ($P=0.000002$).

For men ages 41-55 who had GBS, the incidence of erectile dysfunction was 28 percent (30 of 109 men). Prior to GBS, 2 men (2 percent) were impotent, a significant difference, $P=2 \times 10^{-8}$. In the Kinsey population ages 41-55, 9 of 1,335 men (6.7 percent) were impotent. The difference between the 2 percent rate of impotence prior to GBS and the Kinsey rate of 6.7 percent is statistically insignificant (0.05). However, the 28 percent rate of impotence after GBS is significant.

The incidence of erectile dysfunction in the 56-65 year-old group following recovery from GBS was 52 percent (51 of 99 men). Prior to GBS, 8 (1 percent) were impotent. This change is significant, $P=10^{-11}$. For the Kinsey group between the ages of 60 and 65, the rate of impotence was 25 percent. The difference between our

post-GBS group and the Kinsey group is significant, $P=0.002$.

In our younger population ages 20 to 55 years, the rate of impotence was 23 percent (41 of 175 men). Kinsey reported that 9 of 134 men between the ages of 50 to 55 years were impotent, a rate of 6.7 percent. Using the Fisher exact test, the probability that our population was statistically the same as the Kinsey population is extremely small ($P=0.0001$). Our population was younger than the Kinsey group, but its incidence of impotence was significantly higher.

A large number of men were over 65 years of age, ranging from 66 to over 80 years old. Of 122 men in this group, 74 (61 percent) were impotent. Prior to GBS, their rate of impotence was 20 percent (24 of 122). This change is significant, $P=10^{-10}$.

We could not compare the 66 and older population with the Kinsey statistics since we did not break down this large group by age.

Table 1 shows that the majority of men in the study reporting prob-

lems with impotence had sexual interest and desire and were involved in some form of sexual activity. This finding will be discussed later.

Table 2 displays the relationship between the degree of residual disability and the incidence of impotence in age groups below 56, 56-65, and over 65. Table 2 shows that the greater the residual physical disability, the greater is the incidence of impotence. In patients 55 years and younger there was no difference in the rate of impotence between men who had recovered completely and those who reported only mild residual disability following GBS. In this same age group, those with moderate residual disability and erectile dysfunction were statistically indistinguishable from the men with impotence who reported severe residual physical disability. The difference between the "no/mild" and the "moderate/severe" groups was significant ($P=.00002$).

DISCUSSION

Impotence, or erectile dysfunction, is defined as the inability to achieve and maintain a penile erection sufficiently rigid to permit satisfactory sexual intercourse. Although other sexual functions also may be abnormal, impotence is not synonymous with the loss of sexual interest or desire, or

**Table 1. Impotence following GBS:
A comparison with Kinsey's statistics.**

	All men	Men 20-40	Men 41-55	Men 56-65	Men 66+
Population	396	66	109	99	122
Impotence	166 (42%)	11 (17%) [Kinsey 2%]	30 (28%) [Kinsey 7.7%]	51 (52%) [Kinsey 25%]	74 (61%)
Impotence before GBS	35 (8.8%)	1 (1%)	2 (2%)	8 (8%)	24 (20%)
Still try to make love	122 (73%)	7 (64%)	25 (83%)	35 (69%)	55 (74%)

the ability to ejaculate or to have an orgasm. Erectile dysfunction is considered a common condition in men. It is estimated that 10 percent of men over the age of 21 are impotent.¹¹ The problem may affect as many as 10 to 20 million American men.¹² Though an insignificant finding

Table 2. GBS residual disability: Relationship to impotence.

	All men	Men ≤ 55	Men 56-65	Men 66+
No residual	41	23	7	11
Impotence	10 (24%)	3 (13%)	1 (14%)	6 (55%)
Mild	176	91	42	43
Impotence	56 (32%)	12 (13%)	19 (45%)	25 (58%)
Moderate	128	41	33	54
Impotence	68 (53%)	17 (41%)	18 (55%)	33 (61%)
Severe	51	20	17	14
Impotence	32 (63%)	9 (45%)	13 (76%)	10 (71%)

in the younger male population (0.1 percent at age 20 up to 2.6 percent at age 45), it becomes an important problem by age 60 when the incidence of impotence increases to 18.4 percent. At age 65, impotence affects one-fourth of the male population, and by age 75 over one-half of all men are impotent.¹⁰ Although a more recent study cites a somewhat higher incidence of erectile dysfunction of 5 percent at age 40, the rest of the statistics remain about the same as in the Kinsey report.¹²

The majority of men who have sexual dysfunction have an organic basis for their impotence—vascular, neurogenic, or hormonal.^{10,11} In GBS, autonomic nervous system dysfunction often is present, manifested by urinary retention, gastric atony, constipation, problems with sweating and body temperature regulation,

loss of visual accommodation, and impotence. In its more severe form, marked changes in blood pressure may be present, and even death may occur from cardiac arrhythmias. Recovery is gradual and may be incomplete.¹³

Most nerve fibers of the sympathetic and parasympathetic nervous systems are made up of small (2-6 microns) myelinated or unmyelinated fibers.¹³ Since GBS is an acute demyelinating disease that also may involve the axon, involvement of these fibers causes the dysautonomia seen in this illness. With recovery, repair of the myelin sheath and regeneration of the axon may be incomplete. We feel that this incomplete repair is a reasonable explanation for the significant incidence of impotence found in our surveyed population. It is interesting to note that among the 41 men who felt they had recovered completely, the incidence of impotence was higher than in the general population of the same age group. In addition, 5 men reported that their reflexes had not

returned (12 percent). While testing for reflexes and measuring skeletal muscle strength is easy to quantify, evaluating subtle abnormalities of the pelvic autonomic nervous system is more difficult.

The data suggest that the reported high rate of impotence in GBS is organic in etiology. This conclusion

relies on the above pathologic findings as well as on somewhat indirect argument. First is the recognition that the majority of men who are impotent have an organic basis for their impotence.

In the survey, we questioned patients who also were being treated for hypertension, heart disease, and chronic lung disease. We found no correlation between these illnesses, or medication used to treat these illnesses, and the reported increased incidence of impotence following "recovery" from GBS. Of 52 men with heart disease, 26 were impotent. From our sample in that age distribution, we expected to find 28 men who were impotent. Eighty-three men were on medication for hypertension; 40 of whom were impotent. In the age distribution of our sample, we expected to find 41 men who were impotent. Therefore, we found no increase in the rate of impotence in patients with heart disease or in our men with hypertension who were on medication.

There were only a few men with chronic lung disease. Most were impotent, but the patient population was too small to evaluate statistically.

The only medical condition that seemed associated with impotence was diabetes. There were 18 males with diabetes, and though the number was too small to be statistically significant, 50 percent were impotent following GBS.

None of our respondents reported being depressed or taking medications for depression. The majority of the men who were impotent enjoyed going out socially, and most who were impotent still had sexual interest and desire and still tried "to make love."

In psychiatric and urologic literature, investigators described an interesting clinical observation that helps separate a psychological from an organic cause of impotence. The majority of men who had an organic etiology for impotence still had sexual interests and desires and still tried to "make love." Those whose impotence was psychogenic, generally lost interest in sex and sexual activity.¹⁴⁻¹⁶

Our data, therefore, points to an organic cause for impotence following recovery from GBS. We have suggested that the incomplete repair of damaged autonomic nervous system fibers in the pelvic area is the etiology.

The problems inherent in this study are similar to the problems of all such mail surveys. Participation is purely voluntary, so the results may not apply to the general population of men who have had GBS. However, information about sexuality or sexual function following an illness or injury cannot be obtained by reviewing the records of patients while they are still in an acute care hospital, or even when they are in a convalescent or rehabilitation center.¹⁷ Information regarding sex and sexual function can only be validated once patients have recovered enough to return to the community. A mailed anonymous survey sent after recovery, or when the patient is in a stable state, is the only practical way to gather this information.

The terms mild, moderate, and severe were not defined in the questionnaire. Most of the men who had GBS in our survey were associated with the GBS Foundation. Many had been to support groups or had attended one of the GBS symposia and, therefore, we believe had a reasonable understanding regarding the full range of disabilities that may remain following GBS. Patients were asked to assess their own level of dis-

ability. The data show that in men 55 and under there were only two categories relative to impotence, those who had "no/mild residual" and those who had "moderate/severe residual" disability. Given these two extremes we believe that most men placed themselves in the correct category.

GBS literature does not separate male from female when reporting the percentage of patients left with severe residual disability. In the 754 patients in our initial GBS population, there was reported a 10 percent incidence of severe residual disability, which is in line with the general literature. Our male population had a 13 percent incidence of severe residual and our female population reported only an 8 percent incidence. Perhaps future studies of large GBS populations should be reported by gender.

CONCLUSION

The results of our study of 396 men surveyed more than three years after their acute illness with GBS show a significant increase in the rate of erectile dysfunction compared to the general male population of the same age groups. Our research strongly suggests that the reported impotence is organic and related to the residual autonomic dysfunction following GBS. Furthermore, the impotence seems directly related to the severity of the residual disability.

References are available upon request.

*Dr. Burk is in private practice in Millburn.
Dr. Weiss is a member of the technical staff at Bell Lab.*

THE STUDY REPORTS IMPOTENCE IS ORGANIC AND RELATED TO RESIDUAL AUTONOMIC DYSFUNCTION.

ROBERT JOHNSON

The New Jersey Medicine Interview

Bill Berlin, PhD

ROBERT L. JOHNSON, MD, IS PROFESSOR OF PEDIATRICS AND CLINICAL PSYCHIATRY, AND DIRECTOR OF ADOLESCENT AND YOUNG ADULT MEDICINE AT UMDNJ. HE HAS SERVED AS CHAIR OF THE AMERICAN ACADEMY OF PEDIATRICS' COMMITTEE ON PEDIATRIC WORK FORCE AND OF THE ACADEMY'S TASK FORCE ON THE ACCESS OF MINORITY CHILDREN TO HEALTH CARE. JOHNSON IS A MEMBER OF THE NATIONAL INSTITUTE OF MENTAL HEALTH'S AIDS RESEARCH REVIEW COMMITTEE. HE ALSO HAS SERVED AS PRESIDENT OF THE NEW JERSEY STATE BOARD OF MEDICAL EXAMINERS.

Q. How serious a problem is HIV in adolescents?

A. HIV is a very serious problem. It's been estimated by the Centers for Disease Control that 25 percent of all cases of HIV occur in adolescents and young adults. These youngsters often are least able to take advantage of the newer treatments that are available. These treatments are very effective and are most effective if given early in the infection. The problem is that these young adults are rarely tested, and it may not be another 15 years before they get any symptoms at all.

Q. Is part of the problem that we're dealing with a segment of the

population that has not developed the social or emotional maturity to deal with relationships?

A. We are dealing with a population that is more likely to take the risk that puts them in contact with the infection. They are entering a time of life when they are likely to be more sexually active, experiment with sex, and deal with more partners and more short-term relationships. When it comes to making mature decisions, you'll find that adult populations also are taking risks. Risk-taking is part of being human.

Q. How does this break down in terms of race, gender, or where young people live?

A. The truth of the matter is that in the adolescent population we don't really know, because we don't have any sero-prevalent studies that look at the whole population. If we look at who has been tested, and who has the disease, then it's urban and minority youth and a growing number of women. However, in some of the states that have a small minority population there is a growing number of infections as well. Because those populations outside of the city are least likely to be tested, we just have no idea.

I don't think that there's a great untapped epidemic in suburban areas, but the problem should not be overlooked. The message for physicians is that they have to ask every young adult and adolescent patient if they are sexually active. If they are sexually active then physicians have to test them.

Q. Isn't that a pretty sensitive area, particularly with adolescents who might be very concerned about their autonomy and privacy, or simply may not tell the truth?

A. We find that, in general, they do tell the truth and, by and large, they expect to be asked. One of the

clues to the dimension of the problem is to look at the sexually transmitted disease rates among female students at Rutgers University. Recent studies showed that a very high percentage had human papilloma virus. If, as physicians, our job involves the most serious morbidities, the most serious morbidity in adolescence is sexually transmitted disease. I think any health care provider who is taking care of this segment of the population is doing a disservice by not asking about sexual activity.

Q. How should a physician ask about sexual activity?

A. It is most effective to directly ask if a young adult is sexually active. The patient usually understands what that means, but if not, I ask if the patient has had sexual intercourse. If the answer is yes, I ask if the patient is active with people of the same sex or the opposite sex, and if there is more than one partner. Then we might go into detail about birth control, prophylactics, and types of sexual activities. I've never found a teenager or an adult who does not readily respond to these questions.

Another issue with adolescents is confidentiality. We recommend that every teenager be seen without a parent present, at some point in the visit. We generally see the teenager first, with a parent sitting in the waiting room. Then we speak to the parent alone. Our practice is primarily based on referral, and most people we see are teenagers, so parents expect that's what we're



Robert L. Johnson, MD

going to do. With parents who are not familiar with us, I explain to them the need for confidentiality, which is a requirement of our practice.

Q. Some studies suggest that the youngsters most willing to engage in risky behavior are those who may have problems at home or may be most vulnerable in terms of socioeconomic status. Does this mean that the kids who are most at-risk may never find their way to a physician's office?

A. In our practice, we see a large number of kids for general medical care, and most don't have any serious problems at all. Sometimes, we have this sense that socioeconomic status protects against some problems. Certainly, recent events have proved this untrue, with youngsters from middle-class backgrounds involved in very violent crimes. We have learned that what protects teenagers from violent, risky behavior is their connectedness to their families. That connectedness is not

necessarily a function of socioeconomic status. Some of the youngsters I see who feel less connected are from the wealthier families. The other aspect of this is that sometimes youngsters from the more comfortable communities have the least access to supportive services. For example, a teenager in Smoke Rise, one of the wealthier areas in the state, may have less access to counseling or to contraceptive services than a youngster in Newark.

Q. In terms of this sense of being connected, can a physician play an important role as support or even parental figure for the child?

A. Yes, and it depends upon the nature of the practice and the time available for the physician. The pediatrician tends to grow up with the kids, even spending as much as 15 years as their provider. During trying times, you can even become kind of surrogate parent. The physician can help guide the youngster, but you can only do that if the physician asks about things other than medical issues. We recommend that physicians ask about school, friends, and relationships with family members.

Q. In terms of actually making diagnoses, do doctors sometimes overlook symptoms of AIDS in young people?

A. They sure do, especially when a physician assumes that a youngster from a particular community cannot have the disease. Our late

case is an 18-year-old male from a well-to-do New Jersey community. He had swollen tonsils and thrush. His physicians assumed he had a sore throat and referred him to have his tonsils removed. No one asked him if he was sexually active; no one even thought about HIV. He didn't find out until he volunteered to take an HIV test on his college campus. When we went back into the records and talked to his doctors, they said he was from a very good family, and he couldn't possibly have HIV.

Q. Some experts have argued that we need a larger strategy that includes safe sex education and abstinence programs to combat HIV in young people. Are these programs effective?

A. They have been marginally effective primarily because they have not been instituted in the proper way. Most of these programs stress abstinence and talk about the biology of HIV, and that's about it. Very few of these programs talk about prevention or condoms, and only rarely do they make condoms available to teenagers. And all those strategies work. Abstinence is a wonderful thing, but it's most effectively taught at home. HIV is a public health problem and demands a high percentage of public health resources, yet we're not allowed to take rational public health measures to deal with the illness, such as providing condoms.

Q. Do you ever get frustrated or pessimistic?

A. The support for our programs from every level of government has

been pretty good. I've been very encouraged by the response I've seen to the combination therapies, especially since they have very few side effects. What I see in this illness is a winning of the battle.

Although HIV is a very serious problem for our youth, it's not the most serious problem. Violence and guns are the most serious problems we face.

Q. How can physicians be proactive in terms of preventing violence?

A. They can begin to ask about guns. Now I'm not saying that guns are the root cause of violence. But access to guns and the way parents keep guns in the home are key factors. So physicians need to inquire about that when they speak to parents as well as to teenagers. They also can look for some of the factors that may suggest problems. It gets back to this issue of connectedness. They should ask about what the family structure is like and how active the youngster in is community activities. Loners, or kids who feel that the world is against them, are more likely to be attracted to violence.

Another thing to look for is bizarre behavior—youngsters who mutilate animals, for example. A youngster may not tell you about this, but if you hear about it from a parent or a school nurse, that could be an important sign. It's also important to be available to parents and assist them in getting help. One

of the things that is clear about the case in Oregon is that the parents realized that their son needed help, but they couldn't find it anywhere. One of the things they didn't do was go to the child's physician and ask for advice. A doctor has the legal authority to put a child in a mental hospital and may be more able to get the child serious mental assistance.

Q. Let's say a 14- or 15-year-old youngster you do not know walks into your office. What kinds of questions do you ask him?

A. I ask, Who is in the family? How old are your parents? I ask them to tell me about their health. I ask them how well they get along with family members.

Q. You have to do this in a pretty sensitive way?

A. Yes, you do. We actually have it on a form, and that often helps. If someone sees you filling in things on a form, they are often less resistant to answering questions. We ask teenagers if they have some friends, many friends, or no friends at all and ask them to describe these friends. We ask them if they are involved in community or church activities. We ask about drugs and gambling. We try to be sensitive not only to their answers but to their comfort level, whether or not they are making eye contact. But, surprisingly, most youngsters are very honest, and the kids who are in trouble often want to be helped.

Lowest Premiums for Quality Malpractice Insurance

The Joseph A. Britton Agency can help make it happen. If you are a preferred risk¹, you can qualify for preferred rates². We are also the best source for IPA, PHO, and Healthcare network discounts. Compare these annual premiums at occurrence limits of \$1,000,000/\$3,000,000:

• Internists	\$ 5,331	• General Surgeons	\$18,453	• Neurosurgeons	\$43,448
• Ob-Gyns	\$39,000	• Urologists	\$11,993	• Psychiatrists w/ect	\$ 2,937
• Radiologists	\$ 5,331	• Plastic Surgeons	\$23,350	• Anesthesiologists	\$ 8,572

With 30 years experience, the Britton Agency has proven exceptional in packaging malpractice insurance. Our professional staff and size assure you the benefits of specialized, personal service while offering you quality insurance at the lowest cost.

Call today for a free consultation - Start saving tomorrow



Joseph A. Britton Agency, Inc.

Healthcare & Professional Liability Insurance
855 Mountain Avenue, Mountainside, NJ 07092

(908)654-6464 • Fax: (908)654-1422 • 1(800)462-3401

¹Underwriting approval required. ²May need groups of 3 or more depending on specialty.



Druker, Rahl & Fein

Business Consultants
Certified Public Accountants

We have your prescription to profitability

We're Druker, Rahl and Fein, the accountants and advisors
to physicians and health care providers.

...Managed Care..Government Regulations

..the industry is changing..quickly.

How will these changes affect your practice?

You have questions and you need answers.

Our medical services experts will assist you

in developing a strategy to

succeed in this dynamic environment.

Leaders in:

Cost Accounting • Strategic Planning • Group Practice Formation • Tax
Managed Care Analysis • Practice Valuations • Practice Management

200 Canal Pointe Boulevard • Princeton, NJ 08540-5998 • 609-243-9700 • FAX 609-243-9799

Contact Robert J. Rahl, CPA

2000 YEAR-OLD BUG

THE CLOCK STRIKES MIDNIGHT ON DECEMBER 31, 1999. THE COMPUTER DATE CHANGES TO JANUARY 1, 2000. PROGRAM DATES CHANGE ACCORDINGLY AND BUSINESS CONTINUES AS USUAL—IF YOU ARE PREPARED. BUT, WHAT IF THE DATE CHANGES TO 01/01/00? THE COMPUTER'S PROGRAMMING LOGIC MAY THINK IT IS THE YEAR 1900.

Lauren B. Eder, PhD

The "Year 2000 Bug," the "Millennium Bug," the "Y2K Virus," all refer to the problem that millions of computer programs may encounter when the year 2000 arrives. Doomsday scenarios continue to appear in newspapers on a daily basis. For example, your ATM card could be swallowed up by your bank's automated teller machine because the computer thinks your card has expired. The IRS could



erroneously bill your tax payments as overdue. Social security payments could be affected because the computers that process them miscalculate ages. Worse yet, air traffic control systems could cease to function properly causing global chaos. Is this



Dr. Lauren Eder is working on the year 2000 computer problem.

problem really as dangerous as they say? Potentially yes, if critical computer programs are not corrected before December 31, 1999.

How come no one thought of this computer crisis when programs were being developed? Most programmers in the 1960s, 1970s, and 1980s didn't think their programs would still be in use at the end of the century. Additionally, at the time that many of the computer programs were being developed, system memory and storage were very expensive. Therefore, programming dates with

two digits rather than four digits was more cost effective.

Billions of dollars will be spent by the end of the century to correct all of the programs affected by the year 2000 date change. The global costs for the year 2000 conversion are expected to reach \$300 to \$600 billion. One estimate from the Gartner Group, a Hartford, Connecticut-based information technology consulting organization, suggests that the federal government will

spend \$30 to \$60 billion to convert its computer programs. Most of the affected computers are mainframe and minicomputer "legacy" systems, which have become essential to the backbone operations of organizations. These systems use

programs written primarily in COBOL, a popular programming language for transaction processing systems. The year 2000 problem is not isolated only to large systems, however. Hundreds of thousands of personal computers also will be affected by the date change to the year 2000.

The year 2000 problem will affect health care professionals as well. There are four primary areas of "exposure" where a PC could be affected by the year 2000 date change: the hardware level, the operating system level, the application software level, and the communications interface level.

The BIOS (Basic Input/Output System) is the part of the PC hard-

Year 2000 web sites

- Year 2000 Information Center—
<http://www.year2000.com/>
- Small Business Help
for the Year 2000—
<http://www.sba.gov/y2k/>
- Microsoft Corporation—
www.microsoft.com/year2000

ware responsible for providing basic information that the computer needs to boot or to start running. The BIOS also contains the system's clock. The potential problem with the BIOS is that the year will change to 1980 (the beginning of time for the PC) instead of 2000. As a guideline, PCs made before 1996 are most likely to experience this problem. You should check with the manufacturer of your PC to find out if your system will be affected. The manufacturer will inform you of corrective measures to be implemented to correct the problem.

The second area of exposure is the operating system. Sixteen- and 32-bit versions of MS-DOS, Windows, Windows 95, Windows NT, and Windows CE are all year 2000 compliant. If you have an earlier version of MS-DOS, there is reason to be concerned. You can verify the version of your operating system when your system is booting. Additionally, Microsoft Corpora-

SHARING DATA
WITH A
NON-COMPLIANT
SYSTEM MAY
CORRUPT YOUR
PROGRAMS.

tion has an informative web site dedicated to the year 2000.

Application programs present an additional area of exposure. These are the programs that are installed on a PC and with which the user can interface. Examples are word processing packages like Word or WordPerfect, spreadsheet programs such as Lotus 1-2-3 or Excel, accounting software, and practice management software. Computer application programs may be off-the-shelf or developed specifically for a need. It is important to check with the software developer to be sure that the applications are year 2000 compliant. If not, conversion support is needed. This is especially critical if a medical practice is dependent on the software to man-

age bookkeeping or patient scheduling, for example. Many of the popular medical practice management software programs were developed for and still run on MS-DOS.

Communication interfaces between a PC and other computers introduce an additional exposure. If a PC is exchanging data with other computers, such as hospital systems, insurance company systems, or pharmaceutical company systems, the computer is at risk of accepting "infected" data from those sources. In other words, while your computer may be year 2000 compliant, if it is sharing data with a non-compliant computer, it may receive data with an incorrectly generated date. A simple precaution is to check with organizations that share electronic data to be sure all their systems are compliant.

With less than two years to go, it is imperative to check for year 2000 compliance. ■

Dr. Eder is assistant professor of Computer Information Systems, Rider University, in Lawrenceville.

Medical Society of New Jersey

Long Term Care Insurance Program

Ensuring a Secure Future by Preserving Assets

As medical professionals, you know first hand the devastating effects that extended long term care can have on a person's hard earned assets. The cost of nursing home stays can range from \$3,000-\$5,000 per month. The Medical Society of New Jersey endorses The Travelers and CNA Insurance Companies' policies to help you guard against unforeseen tragedies. Through a special arrangement with The Travelers and CNA Insurance Companies, members, spouses, parents and in-laws are eligible for a premium reduction.

IMPORTANT FEATURES OF THE MSNJ ENDORSED LONG TERM CARE INSURANCE PROGRAM

- ◆ Available Ages 45-84
- ◆ Specialty Plans Available Ages 80-100
- ◆ Benefits up to \$250/day
- ◆ No prior hospitalization required
- ◆ Several waiting periods
- ◆ Alzheimer's, senility covered
- ◆ Lifetime benefits available
- ◆ Guaranteed renewable for life
- ◆ Coverage for custodial, skilled and intermediate care as well as adult day care
- ◆ Available to your spouse, parents and in-laws
- ◆ Waiver of premium benefit
- ◆ Inflation protection available

DISCOUNT FOR MEMBERS OF MSNJ, SPOUSES, PARENTS AND IN-LAWS

For more information, please call

DONALD F. SMITH & ASSOCIATES

A division of THE COPELAND COMPANIES

Two Tower Center, P.O. Box 1063
East Brunswick, New Jersey 08816-1063

(888) 297-7225

Copeland Associates, Inc.

Medical Society of New Jersey
MSNJ

SAD SHEDDING LIGHT ON SEASONAL AFFECTIVE DISORDER

WHEN OTHERWISE HEALTHY PATIENTS FEEL SLUGGISH, DEPRESSED, STRESSED, OR IRRITATED, THINK ABOUT SEASONAL AFFECTIVE DISORDER. THIS CYCLICAL FORM OF DEPRESSION STRIKES TEN MILLION AMERICANS. CAN THESE PATIENTS BE TREATED WITH LIGHT THERAPY AND ANTIDEPRESSANTS? FIRST, THOUGH, THEY NEED TO BE DIAGNOSED CORRECTLY.



Phototherapy helps many SAD patients.

Robin K. Levinson

"I've been so sluggish, wanting to sleep all the time. In the morning, I can barely drag myself out of bed."

"I've felt so utterly depressed and stressed out lately. I cry over nothing. Do I need an antidepressant?"

"My craving for sweets has become almost uncontrollable, especially at night. I've gained eight pounds already, and it's not even Christmas yet."

"I've become so short tempered and irritated over the littlest things. I always seem to get this way after daylight savings time reverts back to standard time, forcing me to drive to and from work in the dark."

When otherwise healthy patients make comments like

these in fall or winter, there is reason to suspect they are suffering from seasonal affective disorder (SAD). Each year, this cyclical form of depression strikes 10 million Americans, many of whom live in New Jersey and other northern states. Research suggests that the vast majority of SAD victims could recover if treated with daily doses of light therapy (phototherapy), antidepressants, or both. However, most people with SAD fail to seek treatment or are misdiagnosed, psychiatrists say. In 1994, it was estimated that 1 in 1,000 people with SAD were treated with phototherapy.

According to the *Diagnostic and Statistical Manual—Fourth Edition (DSM-IV)*, SAD is not an official diagnosis; it is a "pattern specifier" that also can be applied to other mood disorders, such as the depression phase of bipolar disorder I or II, and (most commonly) major depressive disorder—recurrent. What distinguishes SAD from classical depression is that it goes into full remission in spring, usually around April or May, and the patient's mood stays normal throughout the summer. SAD victims may even become hypomanic with the coming of spring, mental health specialists say. Some feel so good they forget all about their depression—until October or November when symptoms re-emerge. It may never occur to them that they have a mental ill-



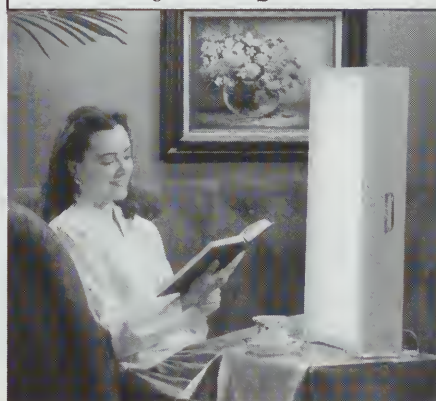
Clifford A. Taylor, MD, is the coauthor of *If You Think You Have SAD*.

ness. [A small minority of patients suffer depression only in the summer.]

Over the course of a typical fall and winter, psychiatrist Steven I. Resnick, MD, treats 10 to 20 patients with SAD in his Princeton office. "They usually begin coming in around the end of September, though early November is when symptoms really start to kick in," Resnick says. "By February, symptoms usually are at their worst."

SAD is characterized by an insidious onset of profound sadness accompanied by a raft of other symptoms, which may include despair, lethargy, fatigue, hypersomnia, intense carbohydrate cravings, social withdrawal, diminished

Enviro-Med light box therapy.



libido, difficulty concentrating, irritability, and anxiety. Weight gain of five to ten pounds or more is not unusual. In the throes of a SAD episode, some people self-medicate with alcohol or illicit drugs. Virtually all become less productive at work, and their relationships with loved ones suffer, as well. Some SAD victims become suicidal.

SAD is diagnosed from a patient's history. It may be useful to speak with a family member, who may confirm a seasonal pattern to the patient's mood changes, says MSNJ member Clifford A. Taylor, MD, a psychiatrist with a private practice in Morristown and coauthor of *If You Think You Have Seasonal Affective Disorder* (Dell, 1998). Premenopausal women sometimes report that their premenstrual syndrome feels worse in the fall and winter. Depression should occur during at least two consecutive seasons before a SAD diagnosis is considered, Taylor says. Unless the doctor is familiar with SAD, he or she might suspect chronic fatigue syndrome, Lyme disease, Epstein-Barr virus, hypoglycemia, thyroid disease, or another metabolic disorder, he adds.

The tendency to interfere with day-to-day functioning is what distinguishes SAD from the less severe "wintertime blues," or subsyndromal SAD (S-SAD). While the estimated 25 million Americans who experience S-SAD do not require antidepressant medication, many can be helped with phototherapy, according to Resnick and Taylor. Phototherapy generally is recommended as a first course of treatment.

Light Box Companies

Appollo Light Systems

352 West 1060 South
Orem, UT 84058

800.545.9667

801.226.2370

Bio-Brite, Inc.

7315 Wisconsin Avenue
Suite 1300W

Bethesda, MD 20814

800.621.5483

Enviro-Med

1600 SE 141st Ave.

Vancouver, WA 98683

800.222.3296

360.256.6989

Hughes Lighting Technologies

34 Yacht Club Drive

Lake Hopatcong, NJ
07849

201.663.1214

Lighting Resources

1421 West 3rd Ave.

Columbus, OH 43212

800.875.8489

614.488.6841

The SunBox Company

19217 Orbit Dr.

Gaithersburg, MD 20879

800.548.3968

301.869.5980

"Phototherapy has no side effects, and patients typically notice an improvement in their mood within three to seven days," notes Resnick, who developed and managed the Light Therapy Program for SAD at Carrier Foundation in Belle Mead from 1988 to 1993. "Phototherapy is a proved, nonmedicinal treatment for a subtype of depression that has a natural and holistic feel to it—yet also has a strong scientific basis."

The biological basis for SAD is not fully understood, but many researchers believe it involves a "phase shift delay" of certain biological rhythms, including cortisol and melatonin release. Early morning exposure to bright light in the fall and winter may trick the brain into believing it is summertime.

The standard phototherapy treatment is exposure to 10,000 lux for 20 to 30 minutes a day throughout SAD season. High-quality light boxes use fluorescent bulbs, screen out ultraviolet radiation, and are capable of delivering 10,000 lux at a distance of about 15 inches. A phototherapy visor producing a maximum lux of 2,500 also is available. Some, but by no means all, health insurers reimburse the \$250 to \$500 cost of a phototherapy device.

Because some people respond more robustly than others to light therapy, patients may need to adjust the duration and intensity of light exposure before an appropriate combination is found, Taylor

explains. Sixty to 80 percent of SAD patients enjoy a full or partial recovery when they stick to their light therapy protocol, studies show. If an antidepressant also is given, the success rate is higher.

The American Psychiatric Association, the U.S. Public Health Service Agency for Health Care Policy, and the Society for Light Treatment and Biological Rhythms all have deemed phototherapy a legitimate treatment for SAD and have published guidelines for its use. Nonetheless, phototherapy units are not approved by the U.S. Food and Drug Administration (FDA) as medical devices. Light box companies cannot afford the millions of dollars worth of research that must accompany an FDA application, explains Sherrie Baxter, president of the Circadian Lighting Association, a trade group, and president of Enviro-Med, a light box company in Vancouver, Washington.

"Members of the Circadian Lighting Association make lights that meet research specifications, and we have our boxes sent to an independent testing laboratory that verifies the lux levels we claim are reached at the distances we claim," she says. "Members also adhere to certain advertising and return policy practices." Phototherapy units are sold directly by manufacturers and distributors, who reach patients through doctors, mood disorder units, catalogs, and the Internet.

Baxter says that most of her customers are referred by clinicians. "The physicians obtain a clinical history and make sure SAD is the diagnosis, and then offer guidance," she says.

We know that practicing medicine is your primary concern.

The professionals at Healthcare Management Partners will take away the time-consuming administration and pressures of billing, collections, follow-up, office management, and system maintenance, so you can concentrate on doing what you do best - practicing medicine.

Contact Rosalie Fox or Robert Rahl at 609-734-0443 to find out more.

**Practice Assessments • Billing & Collection •
MIS Systems • Group Practice Formation •
Practice Management • Income Distribution**

**Endorsed Computerized Billing,
Accounts Receivable and
Information Management Company of the
Medical Society of New Jersey**



HEALTHCARE MANAGEMENT PARTNERS

PARTNERS IN PROFIT

200 Canal Pointe Boulevard • Princeton, NJ 08540-5998
609-734-0443 • FAX 609-243-9799

A Division of Health Information Consulting Services, Inc.

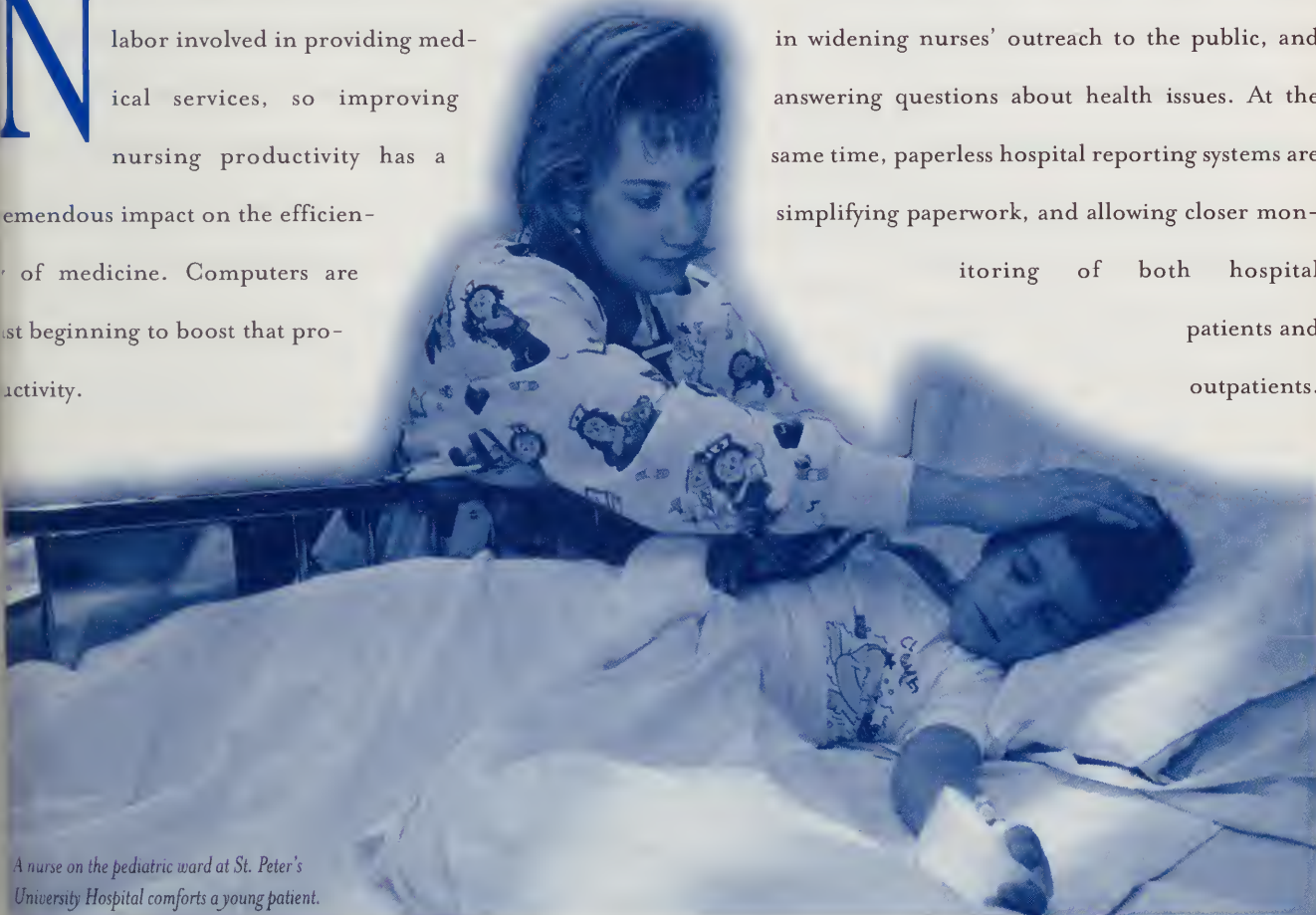
NURSING THE COMPUTER

THEIR CONCERNS ABOUT PAPERWORK AND INEFFICIENCY SOON WILL DIMINISH. NURSES ARE USING COMPUTERS JUST LIKE THEY USE PAPER CHARTS. WITH COMPUTERS BECOMING A BASIC TOOL FOR NURSES, THEIR EFFICIENCY AND PRODUCTIVITY WILL SKYROCKET. IN ADDITION, STEPS IN WIDENING NURSES' OUTREACH TO PATIENTS IS BECOMING A REALITY WITH THE WORLD WIDE WEB. THIS IS A WIN-WIN SITUATION FOR PATIENTS AND THE HEALTH CARE COMMUNITY.

Eric J. Lerner

Nurses supply a large fraction of the labor involved in providing medical services, so improving nursing productivity has a tremendous impact on the efficiency of medicine. Computers are just beginning to boost that productivity.

World wide web pioneers are taking the first steps in widening nurses' outreach to the public, and answering questions about health issues. At the same time, paperless hospital reporting systems are simplifying paperwork, and allowing closer monitoring of both hospital patients and outpatients.



A nurse on the pediatric ward at St. Peter's University Hospital comforts a young patient.

One of the main roles of nurses in providing primary care is to answer basic questions that patients have about matters ranging from diet to child-rearing. Since patients in a physician's office or hospital are interested in the same questions and answers, nurses often are answering similar questions repeatedly, but only for a relatively small number of patients. To widen the reach of such basic but useful services, nurses are starting to look to the Internet, which is the cheapest way to reach many patients at once. An example of how this works is the "Ask the Expert" bulletin board on Net Wellness (<http://www.netwellness.org>). Net Wellness is a demonstration project developed by the University of Cincinnati Medical Center with seed money from the National Telecommunication and Information Administration. It is aimed at delivering consumer health infor-

mation and resources via the Internet.

The faculty of the University of Cincinnati College of Nursing and Health supplies content experts to answer questions generated by "Ask the Expert." This bulletin board allows consumers to query health professionals about specific, non-emergency questions and receive online responses, usually within 24 to 48 hours. Compared to a traditional, telephone question-and-answer service, this bulletin board has several important advantages. For one thing, answers to questions are posted on the bulletin board for all to read, so that consumers with similar interests can benefit from questions asked by others. Second, by using the Internet, long-distance telephone costs are eliminated, making possible queries from all

over the country, and, indeed, the world. In its three years of operation, "Ask the Expert" has fielded questions from nearly every state in the union and from as far away as Australia and South Africa. In addition, the written question-and-answer format allows experts time to research the most accurate answers—about 20 to 40 minutes are spent on each answer.

The nursing faculty on the expert panels act as part of a team with pharmacists and physicians, while a librarian directs the questions to the appropriate expert. Question areas include pregnancy, breastfeeding, and newborn care; child development; and breast cancer.

The information flow is not all one way. Since all questions are logged into a centralized system, its easy to analyze the type of information required. One result is that additional material on pediatric skin rashes and lesions has been added to the pediatric nursing curriculum in response to the large number of questions in this area.

Nursing care in the hospital setting.



Since nurses have the most contact with patients in a hospital, frequently in long-term outpatient treatment, they bear the heaviest burden in keeping track of patient records and paperwork. One of the biggest emerging impacts of computers on nursing is in transferring more and more of this record keeping to electronic form, considerably reducing the labor involved. The Veteran's Administration Domiciliary in White City, Oregon, provides residential treatment for veterans with psychiatric, geriatric, addiction, medical, physical, and vocational rehabilitation needs. Over the last decade, the Domiciliary has moved to an entirely computerized patient record system (CPRS).

In the CPRS, laboratory results, histories, physicals, radiology reports, dietetic orders, allergies, and vital signs are all entered directly in the system, via scanning or dictation and transcription. As a result, many nursing processes have been

IN THE FUTURE, SYSTEMS COULD ALLOW FOR ALMOST CONTINUOUS MONITORING OF PATIENT PROGRESS.

shortened, with verbal orders nearly eliminated. There is no down time waiting for records to arrive and, notes are more available, as are vital signs. In addition, there are more entries of both notes and vital signs, due to the increased ease of use of the electronic system.

Information is easier to retrieve and it is more reliable. A health summary, tailored to the nurse's needs, is available for each patient. Finally, routine orders, such as diets with no change, are generated automatically by the system, freeing nurses from repetitive paperwork.

Some computer systems can ease the task of planning care for long-term patients. In critical pathway monitoring, the patient's progress continuously is compared with a standardized treatment plan with

goals and timelines, and adjustments made if the patient falls behind the goals. Such an approach involves considerable record keeping, and a recently developed software package called Intelligent System Access to Automated Clinical Charting (ISAAC) eases some of this work. ISAAC, developed by Nursing Systems International, in Bordentown, supports nurses in formulating care plans for disabled patients. Nurses begin by selecting self-care deficits from which the patient suffers, such as limitations on the ability to feed, dress, or perform other vital activities. By selecting from a menu of choices, a nurse draws up a plan to minimize these deficits, with treatments and goals for resolution. Once a plan is developed, the system can be used to monitor patient progress and alert the nurse to the need for different treatments. In the future, more advanced versions of such a system could allow almost continuous monitoring of patient progress in acute care facilities, making early intervention possible when patients are not progressing.

ImageFIRST™

MEDICAL WEAR

- Lab Coats
- Dental Jackets
- Patient Gowns • Towels
- Sheets • Pillow Cases
- And More

For Information Call
1-800-408-0370

**ONE WEEK FREE
SERVICE WITH MENTION
OF THIS AD!**

THE LOW-COST BROKERAGE WITH THE HIGH STANDARD OF SERVICE

**LOW
COMMISSIONS**

T. Rowe Price Discount Brokerage combines low* commissions with responsive service. Conveniently buy and sell individual stocks, bonds, and options through our investment representatives or by automated phone, fax, and Internet services 24 hours a day.

Along with keeping down the cost of trades, you'll gain the advantage that comes from one of America's leading investment managers. With more than \$140 billion under management including our affiliates, over 75 mutual funds, and 60 years of experience, T. Rowe Price brings the added value of quality service from an investment firm you can trust.

**Call 24 hours for your free
discount brokerage kit or
to request a prospectus**

1-800-541-4540
www.troweprice.com

Invest With Confidence

T. Rowe Price



*Based on a September 1998 survey for representative-assisted stock trades. Services may vary by firm. Commissions may vary on size of order. T. Rowe Price Discount Brokerage is a division of T. Rowe Price Investment Services, Inc. Member NASD/SIPC. Read the prospectus carefully before investing in any mutual fund.
T. Rowe Price Investment Services, Inc., Distributor.

DB044865

ATTENTION PHYSICIANS:

Do you feel like you need an MBA to navigate the requirements of assigned claims?

Medi-Bill Associates can help you get your MBA without going back to school!

Our Experts:

- Review claims for accurate CPT-4 & ICD-9 Coding
- Submit Claims Electronically
- Follow-up on all submitted claims

Our Products and Services enable you to:

- ***M**aximize assigned insurance receivables
- ***B**ill easily, effectively and efficiently
- ***A**ccelerate practice cash flow

**WE ARE THE ONLY MEDICAL BILLING ORGANIZATION THAT PAYS
PHYSICIANS ON THEIR ASSIGNED CLAIMS WITHIN 72 HOURS!**

Don't Just Bill . . . **MEDI-BILL!**



Medi-Bill Associates, Inc.

Advance Funding/Electronic Billing

800-546-2414

You **CAN** be paid on assigned claims within 72 hours! Call for a **FREE** consultation!

PREVENTING BREAKS

OSTEOPOROSIS AND BMD MEASUREMENT

OSTEOPOROSIS IS HIGHLY PREVALENT AND PREVENTABLE. IT IS READILY DIAGNOSED BY BONE MINERAL DENSITY MEASUREMENT. THERE ARE PREVENTIVE MEASURES TO TAKE: ESTROGEN HORMONE REPLACEMENT THERAPY (HRT), DIET, AND EXERCISE. AND TREATMENT IS AVAILABLE, INCLUDING HRT, BIPHOSPHONATES, AND CALCITONIN.

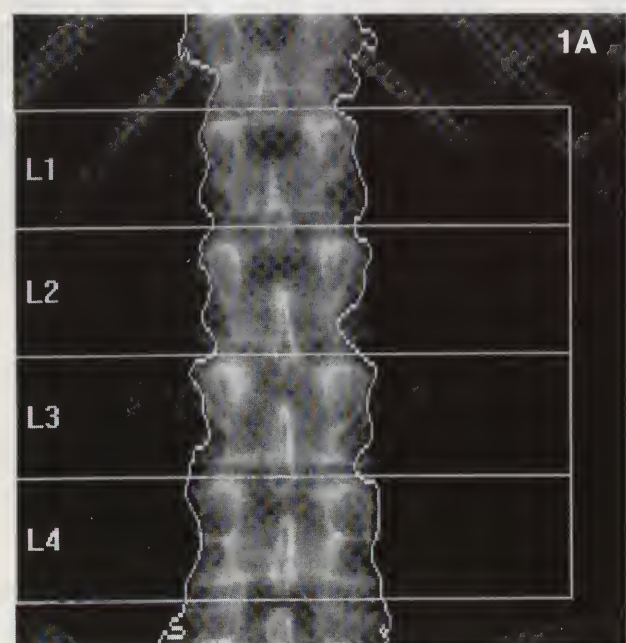
Julie Kelter Timins, MD

Osteoporosis is a disease characterized by low bone mass and microarchitectural deterioration, leading to bone fragility and increased risk of fracture. Bone is built up over the first three decades of life. Between the ages of 30 and 40 years, bone tissue begins to disappear. In women, bone loss accelerates to 1 to 4 percent per year during the first 10 years after menopause. Bone loss then slows down, only to accelerate again around 60 years of age.^{1,2} Factors influencing osteoporosis risk include age, gender, eating disorders, weight, genetics, hormonal status, medications, smoking, and exercise. The most important preventable risk factor is low bone mineral density (BMD). Bone density is the single best predictor of fracture risk. Fractures caused by osteoporosis are termed insufficiency fractures, and most commonly occur in the vertebrae, hips, and wrists. Other factors contributing to insufficiency fractures include falls,

impaired sight, imbalance, sensorium-altering medications, and decreased muscular coordination and strength.

Due to postmenopausal bone loss, lower peak bone density, longer average life span, and a greater propensity to fall, women are at greater risk than men for osteoporotic fractures. Fifty percent of women and 12 percent of men over the age of 50 will develop osteoporosis-related fractures.³ Vertebral and hip fractures are of great concern because they result in a significant deterioration in quality of life, pain, and decreased mobility. Hip fractures in the elderly are associated with a 50 percent disability rate and a mortality rate of 20 percent within one year of fracture. The resultant financial burden is significant. In the United States, the cost of osteoporotic fractures is over \$10





Region	BMD ¹ (g/cm ²)	Young-Adult ² %	T	Age-Matched ³ %	Z
L1	1.089	96	-0.3	100	0.0
L2	1.199	100	0.0	104	+0.4
L3	1.211	101	+0.1	105	+0.5
L4	1.192	99	-0.1	103	+0.3
L2-L4	1.200	100	0.0	104	+0.4

Region	BMD ¹ (g/cm ²)	Young-Adult ² %	T	Age-Matched ³ %	Z
Neck	0.997	102	+0.1	109	+0.7
Wards	0.853	94	-0.4	105	+0.3
Troch	0.848	107	+0.5	111	+0.8
Shaft	1.262	—	—	—	—
Total	1.071	107	+0.5	112	+0.9

Figure 1. Dual-x-ray absorptiometry study of a 47-year-old woman shows normal BMD in multiple sites in (A) the lumbar spine and (B) the proximal femur. All measurements are less than 1 SD below the mean for young adults (T score of <-1.0).

billion annually, and is expected to increase as longevity increases.⁴ Costs include hospitalization, surgery, rehabilitation, long-term care, loss of working days, and medications.

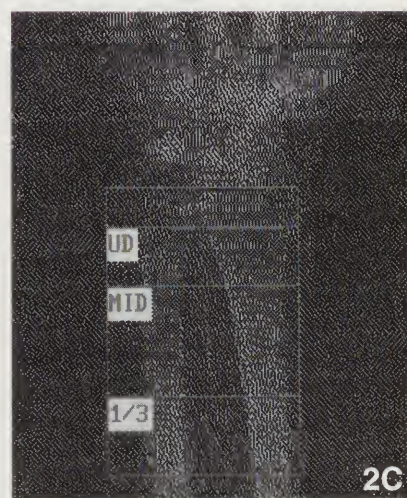
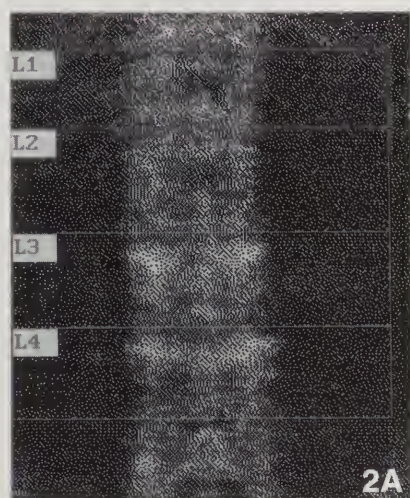
The World Health Organization has defined normal bone density, osteopenia, and osteoporosis in terms of comparison with bone density measurements in normal young adults from the same population.⁵ Choosing a reference population can be problematic. Ideally, the reference population should be 20 to 30 year olds of the same gender,

ethnic or racial background, and geographic location as the patient. Normal bone density is within one standard deviation (SD) of the mean value for young adults. Osteopenia, or reduced bone mass, is defined as BMD between 1 and 2.5 SDs below the young adult mean. A bone density of less than 2.5 SDs below the mean constitutes osteoporosis. The term manifested osteoporosis refers to BMD of less than 2.5 SDs below the mean and the presence of at least one insufficiency fracture. For each SD below the normal range, fracture risk increases by two- to threefold.

Sites in either the axial skeleton (hip, pelvis, and spine) or the appendicular skeleton (extremities such as radius, wrist, and heel) may be measured for bone density. A low value at one site is sufficient to establish a diagnosis of osteoporosis.

BONE DENSITY MEASUREMENT

Only one-half of the population with osteoporosis is identified clinically by primary care physicians.⁶ Given the failure of clinical detection, the determination of BMD is the first step in diagnosing osteoporosis and assessing fracture risk. If



Region	BMD	T(30.0)	Z
L1	0.543	-3.47 59%	-1.94 72%
L2	0.627	-3.64 61%	-1.94 75%
L3	0.716	-3.34 66%	-1.55 81%
L4	0.714	-3.65 64%	-1.81 78%
L1-L4	0.657	-3.55 63%	-1.82 77%

BMD (Total [R]) = 0.412 g/cm²					
Region	BMD	T(30.0)		Z	
Neck	0.458	-3.52	54%	-2.04	67%
		(25.0)			
Troch	0.329	-3.71	47%	-2.65	55%
		(25.0)			
Inter	0.475	-4.03	43%	-3.11	50%
		(35.0)			
TOTAL	0.412	-4.35	44%	-3.16	52%
		(25.0)			
Ward's	0.268	-3.98	37%	-1.75	57%
		(25.0)			

BMD (Radius + Ulna[L] 1/3) = 0.375 g/cm²					
Region	BMD	T		Z	
1/3	0.375	-5.32	55%	-3.67	64%
		(20.0)			
MID	0.297	-5.50	50%	-3.77	60%
		(20.0)			
UD	0.231	-3.55	56%	-2.33	66%
		(20.0)			
TOTAL	0.301	-5.16	53%	-3.51	63%
		(20.0)			

• Age and sex matched
T = peak BMD matched
Z = age matched

Figure 2. Dual-x-ray absorptiometry study of a 64-year-old woman with osteoporosis, with mild discrepancy between BMD readings in different anatomic sites. (A) BMD of the lumbar spine averaged for L1-L4 is 3.55 SDs below the young adult mean. (B) BMD for sites in the proximal femur is between 3.52 and 4.35 SDs below the young adult mean. (C) Sites in the distal radius demonstrate BMD values between 3.55 and 5.50 SDs below the young adult mean.

subsequent measurements are performed to assess response to treatment, these should be performed on the same equipment over the same anatomic sites, at least two years apart. Several methods are available utilizing photon absorption, x-rays, and ultrasound. Most methods have good precision (reproducibility of results), but accuracy varies. Accuracy describes how closely the results correlate with actual bone

density, defined by bone ash weight. In theory, this is determined by scanning a spine or femur segment from a cadaver, then vaporizing the bone at extremely high temperatures and weighing it.^{2,7} In practice, reference phantoms of known composition usually are used to estimate accuracy. The most common ways of expressing bone density are in mass per surface area (gm/cm²) or mass per unit volume (gm/cm³).

Single photon and dual photon absorptiometry were the initial means of determining bone mineral density, utilizing a radioactive isotope source. Single photon absorptiometry with I 125 was effective for evaluating the appendicular skeleton, usually the forearm or calcaneus. Dual photon absorptiometry, often with Gd 153, was employed for measurement of BMD of the axial skeleton, usually the spine or hip.

Measurement times were long, the radiation source had to be changed annually at significant cost, and these methods could be skewed by excessive body fat.

X-ray absorptiometry has largely replaced single and dual photon absorptiometry. It is faster, more precise, delivers a lower radiation

dose to the patient, and is less expensive. The energy source is an x-ray tube, which emits an x-ray of one distinct energy for single-x-ray absorptiometry (SXA) or x-rays of two distinct energies for dual-x-ray absorptiometry (DXA).⁷ SXA is used for measuring BMD in the distal radius or the calcaneus. DXA currently is the most commonly used method for determining BMD and is appropriate for evaluation of the spine and proximal femur, and for determination of total body BMD.

The appendicular skeleton also may be evaluated by DXA. Because the sites of greatest concern for fracture are the spine and hip, the areas most often measured in screening are the lumbar spine (L1-L4 or L2-L4) and proximal femur (femoral neck, intertrochanteric region, and Ward's triangle) (Figure 1). Most measurements are performed in the anteroposterior (AP) dimension, but in patients with substantial osteophyte formation in the lumbar region or extensive calcification of the abdominal aorta, lateral BMD measure-

ments of the lumbar spine may be more accurate. Patient positioning can significantly affect the precision of BMD measurements, especially for the hip and lateral projection of the lumbar spine.

Quantitative computed tomography (QCT) of the lumbar spine and hip uses a computed tomographic (CT) scanner with an appropriate software package and a reference phantom. QCT has an advantage over DXA in that it can selectively measure the BMD of trabecular bone, which is more metabolically active than cortical bone. Therefore, it is more sensitive than other techniques in the early detection of osteoporosis and in treatment followup. Early studies of QCT noted lower precision than DXA, higher radiation dose, and longer measurement time. Recent technical improvements have significantly alleviated these problems, making this modality more competitive with DXA.

Radiographic absorptiometry (RA) is an old technique that has recently been brought back, with modifications. An x-ray of the hand is obtained adjacent to an aluminum reference wedge. Computer analysis of the radiograph is used to determine the phalangeal bone mass based upon the optical density of the image. Accuracy and precision can be comparable to DXA. RA is inexpensive, the radiation dose is low and limited to the hand, and the x-ray equipment requirements are modest. However, BMD of the phalanges does not always correlate with BMD of the axial skeleton.

Ultrasound examination of the calcaneus is another method of evaluation for osteoporosis. Parameters measured include speed of sound, broadband ultrasound attenuation, and stiffness.⁸ Advantages of using the calcaneus as the examination site include its large component of trabecular bone and its easy accessibility. Although ultrasound parameters correlate moderately well with BMD measurements by DXA, ultrasound does not measure bone mass. Rather, it provides other information, such as bone elasticity, which is a significant factor in fracture risk. This method is inexpensive, portable, and does not involve ionizing radiation. Problems include lack of precision and questionable accuracy in predicting fracture risk of the hip and spine.⁹

WHERE TO MEASURE BMD

Trabecular bone loss is greater than cortical bone loss with osteoporosis. Therefore, it is preferable to measure sites with a higher percentage of trabecular bone, such as the lumbar vertebrae, distal radius, proximal femur, and calcaneus. A positive correlation has been demonstrated among BMD measurements in the various anatomic sites standardly evaluated. However, peripheral skeleton values do not always reliably predict BMD of the axial skeleton. Values may vary significantly in individual patients, and alterations in one site may not be reflected in another site (Figure 2). BMD of the lumbar spine is most highly correlated with risk of spinal insufficiency fracture. Likewise, BMD of the hip is most highly cor-

related with risk of hip fracture.² If a patient has a BMD in the osteoporotic range in any measured location, clinical intervention should be considered.

PREVENTION AND TREATMENT

A three-phase approach has been described for the prevention of osteoporosis in women. This includes adequate dietary intake of calcium and vitamin D, weight-bearing exercise, and estrogen hormone replacement therapy (HRT). Cessation of smoking should be encouraged, and other risk factors alleviated.

Several different classes of medications are being utilized for the treatment of osteoporosis. The most effective treatment for postmenopausal women is HRT. Over 85 percent of women respond to HRT.¹⁰ Estrogen works in a variety of ways, decreasing bone turnover, increasing calcium and vitamin D absorption, and promoting renal tubular calcium reabsorption. It has the added benefits of reducing the risk of cardiovascular disease and relieving menopausal symptoms, and can significantly increase BMD. It has been projected that HRT could reduce osteoporotic hip fractures as much as 35 to 50 percent.¹¹ Major concerns with HRT include the possible increased risk of endometrial and breast cancers in some women. The use of estrogen-

progesterone combinations can reduce side effects and decrease the risk of endometrial cancer. So-called designer estrogens or selective estrogen receptor modulators are being developed, which hopefully will provide cardiovascular and skeletal benefits without increasing cancer risk.

Biphosphonates are a nonhormonal class of pharmaceuticals that inhibit osteoclast-mediated bone resorption. Alendronate sodium (Fosamax[®]) is the first approved drug in this class. It has been shown to decrease the incidence of new vertebral fractures and can increase BMD in the spine and femoral neck. A significant problem with alendronate is its poor oral absorption, requiring that it be taken after an overnight fast, 30 to 60 minutes before breakfast, with the patient remaining in the upright position during the interim.

Calcitonin has been available for the past 25 years, and has been used largely for the treatment of Paget disease of the bone. Like alendronate, calcitonin also works by suppressing osteoclastic bone resorption. It can cause a modest increase in BMD and has been reported to provide some analgesia for vertebral fractures, but is less effective than alendronate in the treatment of osteoporosis. Calcitonin is administered as a nasal spray and may cause nasal discomfort. Its efficacy can be limited by the formation of antibodies.

HRT, biphosphonates, and calcitonin all should be taken with calcium and vitamin D supplements.

Fluoride therapy has a different mode of action, stimulating osteo-

blast proliferation. In large doses, fluoride actually may increase bone fragility. However, lower doses and slow-release preparations have been reported to prevent vertebral fractures and increase BMD. The Food and Drug Administration has not yet approved fluoride therapy for the treatment of osteoporosis.

Patient compliance with HRT has been a major problem in osteoporosis prophylaxis and treatment. Only 20 percent of postmenopausal women try estrogen therapy, and only 12 percent are taking HRT at any given time. One study has shown that the simple expedient of obtaining a BMD test can increase acceptance of HRT from 20 to 63 percent, regardless of the test outcome. Fifty-two percent of women with normal BMD elected HRT, while 69 percent of osteopenic and osteoporotic women chose HRT.¹⁰ Treatment of patients with low BMD has been shown to significantly decrease subsequent fracture rates.

CONCLUSION

Osteoporosis is a highly prevalent, preventable disease, with significant morbidity, mortality, and cost to society. BMD determination is the best means of diagnosing osteoporosis and predicting fracture risk. The best strategy is to prevent bone loss and to promote early treatment of osteopenia, prior to the occurrence of osteoporosis and associated insufficiency fractures. ■

References available upon request.

Dr. Timins is staff radiologist, Christ Hospital. She is a member of the MSNJ Council on Communications.

FOR SALE MOBILE VASCULAR LAB

Life Sciences "modulab" mint condition. Modules: Arterial, Venous PVR, CWDoppler, PPG, Phonoangiogram, probes, 5 pairs cuffs, stereo headphones, remote, foot pedal, color screen, Fujitsu color printer, current software, archiver, add'l modules available, custom wheeled cart, free company tech training, \$13,500. Fully deductible this year. Profitable.

Call 609-384-9000

A Medical Visit to Rome and Florence

May 8-18, 1999

"Perspective on Italian Medicine Today"

Sponsored by Seton Hall University School of Graduate Medical Education. For information call Catriona 973.761.9692, fax 973.275.2370, e-mail aimgb@aol.com.

A+ Electronic Billing Services, Inc.



*Performing Electronic Billing since 1993
with a less than 1% rejection rate!*

- Need help with your revenue recovery?
- Would you like your receivables paid in 48 hours?
- Do you have a drawer full of problem EOB's?
- Let us take care of your billing so you can Take care of your patients!
- You have nothing to lose and money to gain!

Call 609-748-0743 TODAY!

Located at Smithville Professional Center
48 S New York Rd # A-3 - Smithville, NJ 08201
Toll Free : 800-452-0741 ~ Fax : 609-748-8618

DEBORAH HEART & LUNG CENTER • DEPARTMENT OF PULMONARY MEDICINE

CME Course

15TH ANNUAL CLINICAL UPDATE IN PULMONARY MEDICINE

Saturday, December 5, 1998 • Atlantic City Convention Center • Atlantic City, NJ

Designed for Pulmonologists, Internists, Family Practitioners, General Practitioners and Allied Health Professionals
6.75 Credit Hours Category 1 AMA and AAFP
6.75 Credit Hours Category 2-A AOA

P R O G R A M

The Role of Leukotriene Modifiers in the Treatment of Asthma	James E. Fish, MD
Upper Respiratory Tract Infections: Treatment and Complications	Dennis G. Maki, MD
New Developments in Obstructive Sleep Apnea	Allan I. Pack, MD, PhD
Diagnosis and Treatment of Fungal Infections of the Lung	Dennis G. Maki, MD
New Treatment Strategies in Adult Respiratory Distress Syndrome ...	James E. Gadek, MD
Update on the Management of COPD	Michael A. Grippi, MD
Diagnosis and Management of Interstitial Lung Disease	James E. Gadek, MD
New Developments in the Early Detection of Lung Cancer	David M.F. Murphy, MD

For further information, please contact:

CME Department

Center for Bio-Medical Communication, Inc.

433 Hackensack Avenue, 9th Floor, Hackensack, New Jersey 07601

201/342-5300 Fax: 201/342-7555 E-mail: cmelinfo@cbcbiomed.com

ALFENDA

EVENT

DATE

LOCATION

November

Society of Anesthesiologists	November 17, 1998	Forsgate Country Club, Jamesburg, AMNJ, 718.275.1911
Gastroenterological Society Dinner	November 18, 1998	The Manor, West Orange, AMNJ, 609.275.1911
Emerging Infectious Diseases	November 18, 1998	St. Mary's Hospital, Passaic, AMNJ, 609.275.1911
Opportunistic Infections in Patients with HIV	November 18, 1998	Vineland Developmental Center, Vineland, AMNJ, 609.275.1911
University Hospital Endocrine Rounds	November 18, 1998	University Hospital, Newark, AMNJ, 609.275.1911
Medical Grand Rounds	November 18, 1998	VA Medical Center, East Orange, AMNJ, 609.275.1911
Endocrinology Lecture	November 18, 1998	VA Medical Center, East Orange, AMNJ, 609.275.1911
Therapeutic Communities and Substance Abuse Treatments	November 19, 1998	Carrier Foundation, Belle Mead, AMNJ, 609.275.1911
Society of Pathologists Meeting	November 21, 1998	Robert Wood Johnson Medical School, Piscataway, AMNJ, 609.275.1911
Neurotoxicity of Common Drugs	November 25, 1998	St. Mary's Hospital, Passaic, AMNJ, 609.275.1911
University Hospital Endocrine Rounds	November 25, 1998	University Hospital, Newark, AMNJ, 609.275.1911
Medical Grand Rounds	November 25, 1998	VA Medical Center, East Orange, AMNJ, 609.275.1911
Endocrinology Lecture	November 25, 1998	VA Medical Center, East Orange, AMNJ, 609.275.1911

December

Worker Mistreatment	December 2, 1998	Union Hospital, Union, AMNJ, 609.275.1911
Chronic Bronchitis	December 2, 1998	Clara Maass Medical Center, Belleville, AMNJ, 609.275.1911
Director Board	December 2, 1998	The Hyatt Hotel, New Brunswick, AMNJ, 609.275.1911
University Hospital Endocrine Rounds	December 2, 1998	University Hospital, Newark, AMNJ, 609.275.1911
Medical Grand Rounds	December 2, 1998	VA Medical Center, East Orange, AMNJ, 609.275.1911
Endocrinology Lecture	December 2, 1998	VA Medical Center, East Orange, AMNJ, 609.275.1911
Psychiatry and the Information Super-Highway	December 3, 1998	Carrier Foundation, Belle Mead, AMNJ, 609.275.1911

CALENDAR

EVENT

DATE

LOCATION

December

Social Epidemiology of HIV/AIDS	December 6, 1998	Dept. of Health and Senior Services, Trenton, AMNJ, 609.275.1911
AAD Coding Seminar	December 8, 1998	The Manor, West Orange, AMNJ, 609.275.1911
Chronic Bronchitis	December 9, 1998	Vineland Developmental Center, AMNJ, 609.275.1911
Chronic Fatigue Syndrome	December 9, 1998	Clara Maass Medical Center, Belleville, AMNJ, 609.275.1911
CNS Disorders and Brain Dysfunction	December 9, 1998	St. Mary's Hospital, Passaic, AMNJ, 609.275.1911
Interhospital Endocrine Rounds	December 9, 1998	University Hospital, Newark, AMNJ, 609.275.1911
Medical Grand Rounds	December 9, 1998	VA Medical Center, East Orange, AMNJ, 609.275.1911
Endocrinology Lecture	December 9, 1998	VA Medical Center, East Orange, AMNJ, 609.275.1911
Update in Gastroenterology, Hepatology, and Nutrition	December 11, 1998	College of Physicians and Surgeons, New York, 212.781.5990
Domestic Violence Issues	December 12, 1998	St. Mary's Hospital, Passaic, AMNJ, 609.275.1911
Abnormal Pap Smear	December 16, 1998	St. Mary's Hospital, Passaic, AMNJ, 609.275.1911
Interhospital Endocrine Rounds	December 16, 1998	University Hospital, Newark, AMNJ, 609.275.1911
Medical Grand Rounds	December 16, 1998	VA Medical Center, East Orange, AMNJ, 609.275.1911
Endocrinology Lecture	December 16, 1998	VA Medical Center, East Orange, AMNJ, 609.275.1911
Interhospital Endocrine Rounds	December 23, 1998	University Hospital, Newark, AMNJ, 609.275.1911
Medical Grand Rounds	December 23, 1998	VA Medical Center, East Orange, AMNJ, 609.275.1911
Endocrinology Lecture	December 23, 1998	VA Medical Center, East Orange, AMNJ, 609.275.1911
Interhospital Endocrine Rounds	December 30, 1998	University Hospital, Newark, AMNJ, 609.275.1911
Medical Grand Rounds	December 30, 1998	VA Medical Center, East Orange, AMNJ, 609.275.1911
Endocrinology Lecture	December 30, 1998	VA Medical Center, East Orange, AMNJ, 609.275.1911

INTERNATIONAL COLLEGE OF ACUPUNCTURE & ELECTRO-THERAPEUTICS

(Permanently Chartered by the University of the State of New York,
State Education Department)

ACUPUNCTURE & ELECTRO-THERAPEUTICS in Clinical Practice

1998-99 Seminars & Workshops

25 credit hours can be earned by attending

one three-day weekend (Friday-Sunday) session 9 am-7 pm

Nov. 20-22, 1998 Holiday Inn, Manhattan

Dec. 11-13, 1998 440 W. 57th St, NYC between 9 & 10 Ave.

Jan. 22-24, 1999 Hotel tel. 212-581-8100 during meetings

Feb. 19-21, Mar. 19-24, May 14-16, June 18-20, 1999

In addition to holding 7-8 seminars & workshops per year, the International College of Acupuncture & Electro-Therapeutics organizes an Annual International Symposium every October at the School of International Affairs, Columbia University, NYC and publishes *Acupuncture & Electro-Therapeutics Research*, *The International Journal* quarterly, through Cognizant Communications and is listed by 15 major international indexing periodicals (*Index Medicus*, *Current Content*, *Excerpta Medica*, etc.), is recognized as a major leading journal in the field. The most prestigious and internationally recognized, "Fellow of the International College" (F.I.C.A.E.) will be awarded to members of the College who present a minimum of 2 original research papers during the annual International Symposium and publish them in the official journal, or who have made significant contributions in the field.

These seminars/workshops, int'l. symposium train physicians and dentists in the latest theories & techniques of manual & electro-acupuncture.

For information, contact Dr. Y. Omura, MD, ScD, FICAE, 800 Riverside Drive (8-I), NY, NY 10032; 212-781-6262, Fax 212-923-2279 or Dr. Richard Simon, PhD, 212-662-7022. All ICAE meetings are accredited by the New York State Boards for Medicine and Dentistry towards 300-hour requirement for the Acupuncture Certificate. Also eligible for AMA/CME Category I Credit. This activity implemented in accordance with ACCME, joint sponsorship CE Program MSSNY and SUNY Health Science Center, Brooklyn. MSSNY is accredited by the ACCME to provide CME for physicians. MSSNY designates this CME activity for category one credit towards the AMA/Physician's Recognition Award.

Comprehensive Care for Your Financial Health

M. Sanders & Associates is a full service, all inclusive medical billing, collection and consulting company. We offer professional services to increase your bottom-line profitability by maximizing your reimbursement and improving your productivity.

M. Sanders & Associates has a variety of services available both individually or in combination packages. We can also customize services specifically to meet the needs of your medical practice.

Call Regina Rudd at (609) 661-8011, to arrange for a complimentary consultation and office assessment.

M. SANDERS

ASSOCIATES

Billing, Collection & Consulting Services

A COLLECTIVE WAY TO RESOLUTION

Malpractice insurance policies are strange animals. Beware of the ones with tails.

Most New Jersey malpractice insurance policies require you to purchase a reporting endorsement — known as a tail — to protect against claims that may occur during retirement. B.C. Szerlip offers a unique policy from an A+ rated company that does not include an annual tail premium. In fact, if you maintain coverage with us until retirement, you'll *never* have to purchase a tail, and you'll still be protected.

That's just one example of the creative ways that B.C. Szerlip has discovered to help doctors with their long-range financial planning.

At B.C. Szerlip, we take a big-picture view of your practice, offering you comprehensive insurance and financial planning services. You can benefit from our nearly two decades of experience providing malpractice insurance for medical offices both large and small. In addition, our financial planners can offer strategic guidance for the overall health of your business affairs, so you can stay focused on the health of your patients.

We'd like to give you a taste of our full-service approach by sending you *The Managed Care Survival Kit for Physicians*. To receive your complimentary copy of this useful guide, please call us at 800-684-0876.

BCSZERLIP INSURANCE AGENCY INC.

99 WOOD AVENUE SOUTH, PO BOX 217

ISELIN, NJ 08830-0217

800-684-0876 • 732-205-9800

FAX: 732-205-9496

E-MAIL: bcszerlip@aol.com

*Professional Insurance Services
for Health Care Providers*

Editorial Guidelines

Editorial Guidelines

The principal aim in the preparation of a contribution should be relevance to health care and to the education of health care professionals. The contents of each issue include an important health care development; an indepth interview highlighting a health care newsmaker; an update on a key public health issue; a peer-reviewed clinical report; brief highlights of the latest events and findings in the health care industry; and a monthly forum for readers. Proposals for special submissions will be considered on an individual basis. Letters to the editor are welcome and will be edited and published as space permits. Notices of events, programs, and meetings are encouraged.

Copyright

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or separate statement accompanying material offered to *New Jersey Medicine* must contain the following language, and must be signed by all authors.

"In consideration of *New Jersey Medicine* taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey in the event that such work is published in *New Jersey Medicine*."

Publication Policy

New Jersey Medicine will review original unpublished materials on topics relevant to health care professionals in New Jersey. All submissions are subject to peer review and are edited to conform to the style of *New Jersey Medicine*. Receipt of materials will be acknowledged. Final decision is reserved for the editor. No direct contact between the reviewers and the

authors will be permitted. Upon acceptance, authors will have the opportunity to review edited material. All communications should be sent to *New Jersey Medicine*, Two Princess Road, Lawrenceville NJ 08648.

Specifications

Materials compatible with Microsoft Word 97 for Windows should be submitted on diskette (3 1/2 inch), and should be accompanied by a printed copy of the material, a cover letter identifying the submission, and a copyright form.

The title page should include the full names, degrees, and affiliations of all authors, and the name and address of the author to whom correspondence should be sent.

The author(s) should submit a 50-word abstract to be used at the beginning of the article. References should not exceed 20 citations and should be cited consecutively by superscripted numbers at the end of the sentence. The style of *New Jersey Medicine* is that of *Index Medicus*: I. Goldwyn RM: Subcutaneous mastectomy. *NJ Med* 74:1050-1052, 1977. Tables and graphs should be presented at the end of the article. Illustrations should be of professional quality, black and white glossy prints. The name of the author, figure number, and top of the figure should be clearly marked on the back of each illustration. When photographs of patients are used, the subjects should not be identifiable or publication permission signed by the subject or responsible person must be included. Materials taken from other publications must give credit to the original source. Generic names should be used with proprietary names indicated parenthetically with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol. ■

THE MEDICAL SOCIETY OF NEW JERSEY CLASSIFIED ADVERTISEMENT INSERTION REQUEST

RATES (Placement in New Jersey *MEDICINE* OR on WEB Site)

New Jersey *MEDICINE*

<http://www.msnj.org>
WEB Site

per Month—Non-Members

Minimum 45 words \$ 45.00

plus each word over 45 words \$ 1.00

per Month—Members

Minimum 45 words \$ 30.00

plus each word over 45 words \$ 1.00

per Month—

Minimum 45 words \$ 45.00

plus each word over 45 words \$ 1.00

(Placement in New Jersey *MEDICINE* AND on WEB Site)

New Jersey *MEDICINE*

<http://www.msnj.org>
WEB Site

per Month—Non-Members

Minimum 45 words \$ 45.00 \$ 36.00

plus each word over 45 words \$ 1.00 \$.80

per Month—Members

Minimum 45 words \$ 30.00 \$ 36.00

plus each word over 45 words \$ 1.00 \$.80

PREPARE YOUR COPY ON A SEPARATE PAGE AND ATTACH TO THIS ORDER FORM

INSERTION AUTHORIZATION

Name _____ MSNJ Member? Yes _____ No _____

Company _____ Telephone Number _____

Address _____ Fax Number _____

City _____ State _____ ZIP _____

New Jersey *MEDICINE* Issues _____

Web # of 30 Day Insertions _____

New Jersey *MEDICINE*

Non-Member
Minimum 45 Words \$ 45.00
Each Add'l Word @\$1.00 \$ _____
Per Issue \$ _____
Number of Issues _____
AMOUNT DUE \$ _____

MSNJ WEB SITE

Non-Member or Member
Minimum 45 Words \$ 45.00
Each Add'l Word @\$1.00 \$ _____
Per Month \$ _____
Number of Months _____
AMOUNT DUE \$ _____

New Jersey *MEDICINE*

Member
Minimum 45 Words \$ 30.00
+ Each Add'l Word @\$1.00 \$ _____
Per Issue \$ _____
X Number of Issues _____
AMOUNT DUE \$ _____

MSNJ WEB SITE WITH NEW JERSEY *Medicine* Placement

Non-Member or Member
Minimum 45 Words \$ 36.00
+ Each Add'l Word @\$.80 \$ _____
Per Month \$ _____
X Number of Months _____
AMOUNT DUE \$ _____

TOTAL DUE \$ _____ ALL CLASSIFIED ADS MUST BE PRE-PAID

Please make check payable to "Medical Society of New Jersey"

Mail to: Classified Ad Department
370 Morris Avenue
Trenton, NJ 08611

Tel: 609-393-7196
Fax: 609-393-3759

CLASSIFIED ADS

110 OPENINGS PHYSICIANS (ALPHABETICAL BY SPECIALTY)

BC/BE ANESTHESIOLOGIST

Pain Management Only—New Jersey (Central/Northern—½ hr from N.Y.C. Outstanding private practice opportunity for motivated BC/BE Anesthesiologist. Pain Fellowship is a plus. F/T or P/T. Most established pain group in the state. No night call or w-ends. Excel. Compensation. Avail immed. Fax short C.V. & cover letter to (732) 651-0375.

ENT

ENT Doctors and Graduates: Miracle Ear/Bausch & Lomb/Sears have a full time position available in Toms River, New Jersey to pre-examine hearing aid candidates, seeing approximately 15 patients per day. Salary negotiable plus bonus. No weekends. One evening per week. Start immediately. Call Mark Marquez at 1-609-691-4162 or (NJ) 1-800-437-4327.

BC/BE INTERNAL MEDICINE

BC/BE Internal Medicine Morris County. Well established private practice on staff of Morristown Memorial Hospital seeking PT/FT associate. Fax Resume 973-514-1056.

130 OPPORTUNITY WANTED

GENERAL PRACTICE—ER

51 years old, 23 years medical practice in General Practice and small ER's; seeks only temporary work. Not board-certified or eligible; only 1 year PG. Licensed MO, NJ, Puerto Rico, Virgin Islands, ACLS only. Foreign Graduate (Spain). 314-428-4032.

INFECTIOUS DISEASES/ INTERNAL MEDICINE

Board eligible/certified specialist in Infectious Diseases and Internal Medicine, U.S. citizen, is looking for the opportunity to join group practice in ID or ID/IM, located in northern/central NJ, available in 7/99. Please call 516-352-4852.

PSYCHIATRIST

To rent space or work on fee for service basis ½-1/day per week in busy neuropsychology practice working with adults and children in Lawrenceville, NJ. Call Dr. Jon Willard-Mack at 609-895-9784.

200 PRACTICE FOR SALE

OPHTHALMIC PRACTICE FOR SALE

Retiring physician/surgeon with successful thirty year practice and impeccable reputation for quality care, seeks interested buyer. Physician will stay on to ease transition. Pleasant practice environment with excellent staff in very affluent New Jersey community 45 minutes from NYC. No HMO's. Terrific potential for ambitious physician to expand into refractive, plastics or managed care. Large wonderfully equipped office in physician's own building. Real estate is negotiable. Respond in confidence by Fax to (908) 756-7436.

300 OFFICE RENTALS AND LEASES

EDISON

Office Space—Edison Medi-Plex Building opposite J.F.K. Hosp. Fully equipped, turn-key. Rent day, full day, night. 732-494-6300.

EDISON

Modern Medical Office Space—Sublease Up to 2000 Square Feet. Fully equipped with on-site Surgery Center available. Suitable for Endoscopy, Surgical procedures, etc. Call Denise—732-549-2975.

EDISON

2 Office Suites, available 4/1/99 (1766 & 1214 sq ft). Set-up for medical office. X-Ray apparatus available (1,766 sq ft office). Very attractive building and offices. 732-549-7712.

ELIZABETH

Fully operative office at 430 Morris Ave (optimal location). Border of Elizabeth & Union. Fully equipped including X-Ray & fully furnished. Ample parking in private lot. Avail immed. Weichert 973-376-4545. Lanie or Kari.

LAKE HOPATCONG— MORRIS COUNTY

Medical Office Space. 2,000 Sq. Ft. Fully equipped. Occupied 35 years. Ideal for partnership or small group. Lake Hopatcong. 973-663-5306.

LAWRENCEVILLE

Psychiatrist—to rent space or work on fee for service basis ½-1/day per week in busy neuropsychology practice working with adults and children in Lawrenceville, NJ. Call Dr. Jon Willard-Mack at 609-895-9784.

MARLBORO

Medical Complex—Fully equipped 1200 Square Feet of Medical Office space for Lease—Excellent Location Call Dawn—732-238-7600.

MILLBURN

Medical Arts Building. Millburn Avenue. Fully equipped, turn key. Rent day, ½ day, night. Call 973-376-8670.

PARSIPPANY-MORRIS PLAINS

Medical Arts Plaza, 2839 route 10 (opposite Powder Mill West), ParsIPPany-Morris Plains. 925 S.F. Large Waiting Room. Large Private Office. 2 Exam Rooms with sinks. Utility Closet. Manager's Office. Work Station with sink/vanity. Lavatory. New Carpets. New Central HVAC. Professional Atmosphere. Building recently purchased and extensively renovated. Impressive Demographics. Plus an additional 1,435 S.F. available soon. Call Owner—973-228-5879.

330 MEDICAL BUILDING FOR SALE

BAYSHORE-HOLMDEL

Bayshore/Holmdel Medical Building. 14,000 sq. ft. adjacent to Robert Wood Johnson/Bayshore Medical Center. Elevator, grade level access to two floors, leased, prestige brick building on great corner. \$1,200,000. Stafford Smith LLC Commercial Realty Brokerage. 732-517-0100.

RED BANK—MERIDIAN HEALTH

Red Bank/Meridian health. 3,500 sq. ft. medical office condominium adjacent to medical center. Elevator, parking, very convenient location, set up for two practices. \$349,000. Stafford Smith LLC. Commercial Realty Brokerage. 732-517-0100.

340 MEDICAL OFFICE FOR SALE

PATERSON

3 Furnished offices—2 Apartments—528 & 528 Broadway at 23rd Street, Paterson, NJ. Call Dr. Nessman 973-942-6622.

520 NEW EQUIPMENT— LEASING/FINANCING

EQUIPMENT LEASING/FINANCING

HPSC specializes in financing healthcare practice equipment, working capital, leasehold improvements, supply contracts, start-ups. Low competitive fixed rates. Response within an hour, by phone or fax. Over 72,000 doctors financed with incredible service! \$150,000 application only. All contracts funded, serviced in house. We do not sell your contract to disinterested third parties. On practice acquisitions, buy-ins, we finance up to 100% of selling price. Apply over the Internet; www.hpsc.com (secure site)! HPSC Financial Service: 800-225-2488, Fax 800-526-0259.

900 MISCELLANEOUS

INTERNET SERVICES

Internet Services—Are you using the Internet stay up to date or earn CEU's? Interested developing a web site but not sure where start? Call 609-631-8529 to schedule a FREE session on using the Internet to enhance your practice.

EMERGENCY PHYSICIANS

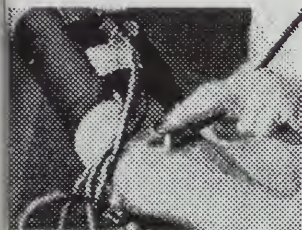
Emergency Physician Associates, a Team Health affiliate, is seeking quality ED physicians for a variety of practice opportunities in NJ, PA, DE, MD, NC and NY.

We offer physicians competitive compensation, flexible schedules, malpractice insurance, a variety of practice settings, and supportive Medical Directors.

Interested candidates may call

1-800-848-EPA-1.

A NEW PACE IS SET FOR MEDICAL OFFICES



Your medical practice is a business, and if that business does not run efficiently, it will affect your patient and public relations. I'm Mary Ann Hamburger, and I've set a new pace for your administrative office personnel, that's steady

and streamline. Simply call one number for a complete turn-key approach, assuring peak performance in your office. I'll hire and train your staff and help with patient flow. I'll reorganize your billing systems and update all of your CPT and ICD codes. I can even help you *sell your practice*. You know what you need, but handling it is tedious. Rely on an *expert*. Let me evaluate, recommend and reorganize your total office.

OFFICE REORGANIZATIONS
START TO FINISH

MARY ANN HAMBURGER

A S S O C I A T E S

THE SPECIALIST'S SPECIALIST

74 HUDSON AVE. MAPLEWOOD, N.J. 07040

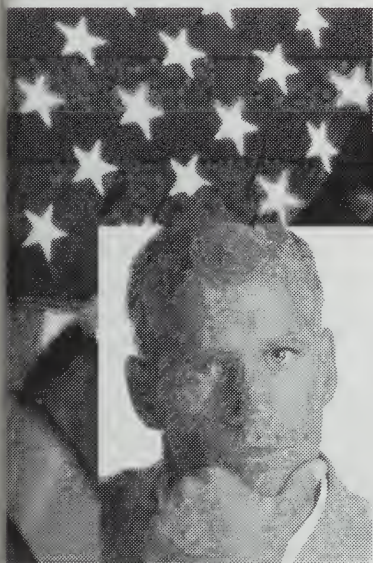
973-763-7394

VICE PRESIDENT OF MEDICAL AFFAIRS

Bayonne Hospital, a progressive 299 bed acute care community hospital located in Hudson County, is currently seeking a dynamic, highly motivated individual to fill the position of Vice President of Medical Affairs. The successful candidate must be a licensed physician in the State of New Jersey and board certified in his/her field of practice. He/she will have broad experience as an attending physician with excellent clinical and administrative experience.

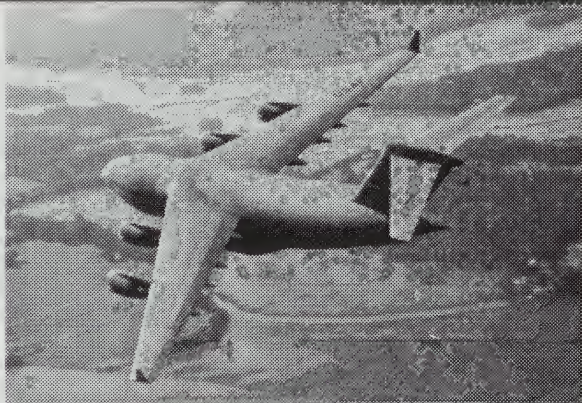
Reporting to the President and CEO, the major responsibilities of this full time position will include acting as liaison between the Medical Staff and administration, supporting the President of the Medical Staff, assuming responsibility for quality improvement and ensuring Medical Staff compliance with regulations for the State Department of Health, Joint Commission on Accreditation, as well as all other regulatory agencies.

Bayonne Hospital is an affiliate of Atlantic Health System, one of the largest healthcare networks in New Jersey. For immediate consideration, please mail or fax resume to Bonnie Keeler, M.D., Russell Reynolds Associates, 200 Park Avenue, New York, NY 10166. Phone: (212) 351-2000; Fax: (212) 286-1863; E-mail bkeeler@russreyn.com.



PHYSICIANS

TAKE YOUR
MEDICAL
CAREER
ABOVE &
BEYOND



If you're a physician looking for a change of pace above and beyond the ordinary, consider becoming a commissioned officer/physician with the Air Force Reserve. As in civilian life, Air Force Reserve physicians provide critical and preventive care and vital clinical services.

APN 25-801-0002

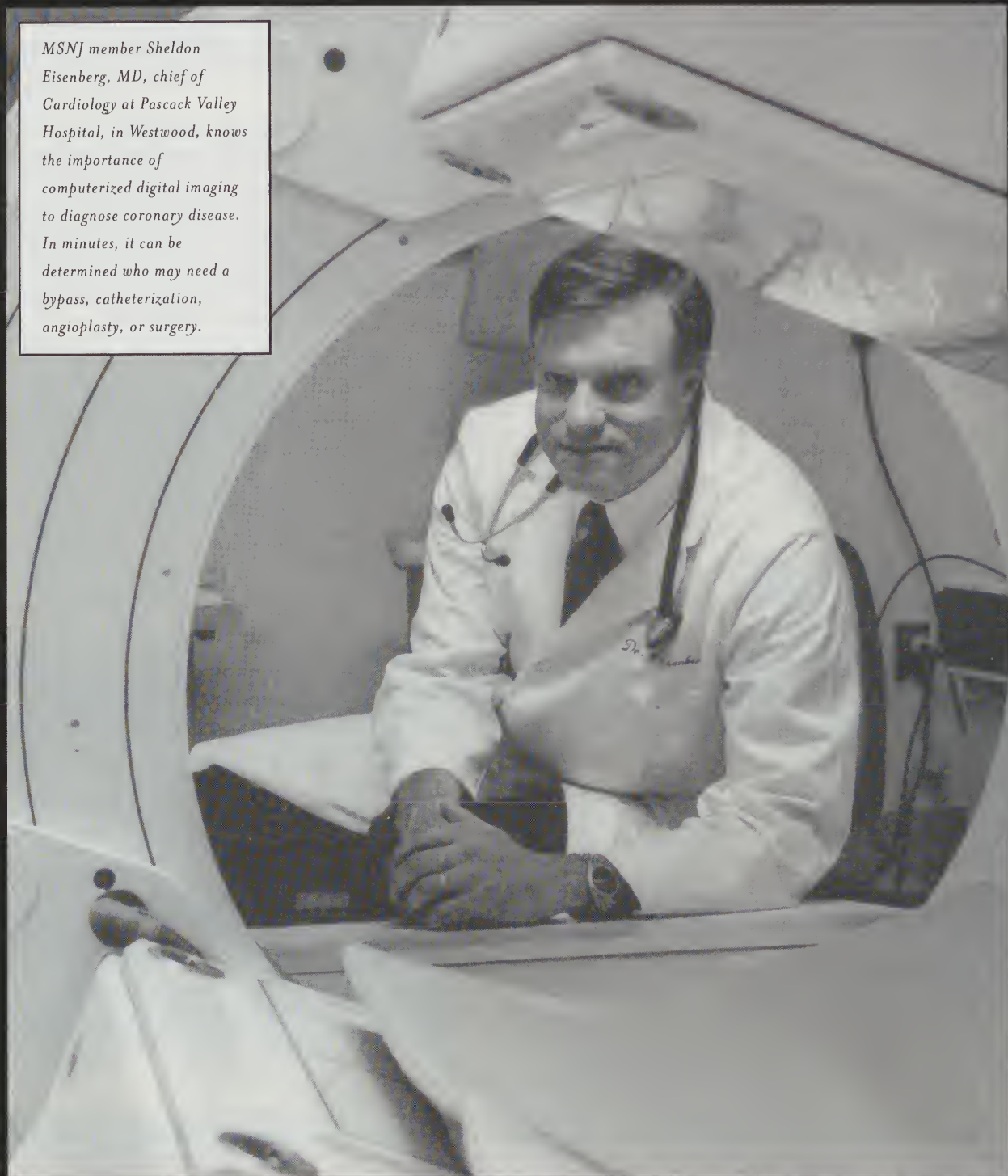
However, as a Reservist, your medical expertise can take you around the globe and into real-world scenarios that will take healing above & beyond. Air Force Reserve physician/officers hold a position of special trust and responsibility. Combined with training opportunities in areas such as Global Medicine and Combat Casualty Care, paid CME activities, you will find yourself among an elite group of health care providers. All it takes is one weekend a month and two weeks per year. Feel the pride of doing something above and beyond for your country while adding a new dimension to your medical career.

Call 1-800-257-1212. Or visit our web site at www.afreserve.com.


**AIR FORCE
RESERVE**
ABOVE & BEYOND

Photo Finish

MSNJ member Sheldon Eisenberg, MD, chief of Cardiology at Pascack Valley Hospital, in Westwood, knows the importance of computerized digital imaging to diagnose coronary disease. In minutes, it can be determined who may need a bypass, catheterization, angioplasty, or surgery.



We welcome contributions to Photo Finish (color or black-and-white). Please include a 50-word description of the photograph. Send to Editor, New Jersey Medicine, Two Princess Road, Lawrenceville NJ 08648. Photographs will be returned.

NEW JERSEY MEDICINE

HEALTH CARE IN THE GARDEN STATE

DECEMBER 1998

Dr.
William
Hait

People of the Year

Texas Medical Assoc
Journal Office
401 West 16th St
Austin, TX 78701

Governor
Christine
Todd
Whitman

plus

Courtroom Credibility

Lessons to learn from malpractice cases

The Blanksteen Companies

We use both Association and individual insurance plans to arrange the combination of coverage and price that best serves you.

Call Blanksteen For

All Your Insurance Needs.

Endorsed By
The Medical Society
Of New Jersey

The Blanksteen Companies
P.O. Box 18, Jersey City, NJ 07302

(800) 252-6524

DEC 28 1998

AUSTIN, TEXAS

Newswatch

Is it the message or the method?

At century's end, we in the United States hear a cacophony of messages. Our opinions are molded through cellular telephones, facsimile transmissions, and Internet and intranet technologies; through face-to-face meetings and conferences facilitated by robust transportation systems; through voice mail, overnight delivery services, and an explosion of newsletters produced in computerized formats; through automated information systems, public radio and call-in shows aired while we travel; and, perhaps most visibly, through cable and satellite television offering viewers dozens of contemporaneous program choices. Sophisticated telemarketing and broadcast and mail marketing strategies exploit all these media.

How wondrously strange, then, that discourse in the health care field is dominated, not by masters of communication who bring disparate communities together, but, rather, and increasingly, by oppos-

ing choruses of shrill and hostile voices. Most notably, on one side physicians and other health care providers sing out in praise of personalized health care and lambaste third-party payers. Across the stage, the managed care choir hums melodies of rapture for efficiency and standardization and mocks health professionals as poorly adapting victims of progress.

And both camps are right about their own virtues. And both camps are wrong about the vices of their antagonists. And neither side gives way, because each is so sure of the justice of its cause.

In this year's last issue of *Health Affairs* former HMO executive Ross Goldberg lists ten steps that HMOs might take to regain the public trust. Mr. Goldberg's prescription is so deeply rooted in conventional communication approaches as to appear glaringly obvious. The advice is almost certain to be ignored, as HMOs continue to try to take people's minds and hearts by other, more finan-

cially and more politically based, methods.

Included among the steps are putting members first always, engaging physicians as allies, talking more freely about ethics, and candidly discussing the cost-quality tradeoff. Then there is this: "Stop doing silly things," says Mr. Goldberg. "HMOs vehemently oppose moving toward 'body-part'

Can physician offices increase productivity and efficiency in a gentle way? "Volume planning" now is put forward as a method to fit the appointment to the patient. A practice devises a "visit map" that classifies patients as chronic, complex, or episodic. A separate protocol is established for each class. For example, complex patients are interviewed by telephone in advance by a nurse, who fixes a length of time for the office appointment. Volume planning is described in *The Physician's Advisory* in a piece summarized by the *Healthcare Leadership Review*.

legislation, yet one of the largest health plans thought nothing of advocating a specified time period for new mothers to be discharged from the hospital." With a heretic's certainty, he goes on to criticize HMOs for centralizing utilization decisions in their own executive offices rather than relying on independent peer review.

Physicians commonly resist standards-based performance review. In clinicians' minds there usually is some reason why a particular measure is not quite valid or appropriate or consistently applied. *Medicine & Health Perspectives* describes the efforts of a few health plans, such as Intermountain Health Care headquartered in Salt Lake City, to shift from financial management to clinical management.

Intermountain assesses physicians' patient satisfaction and uses benchmarking to promote better performance by health care teams. Intermountain vice-president Brent James, MD, says, "I expect physicians to respond by thinking about how they deliver care relative to their peers, and to be willing to test new ideas." He adds, "With very few exceptions, physicians are really interested in providing the best possible care. The question is, how can we support them in that?"

Medicine & Health Perspectives also credits the American Medical Accreditation Program (AMAP) as "one of the most important new programs" in performance measurement. Created by the AMA, which first launched the project right here in New Jersey in conjunction with the Medical Review

and Accrediting Council, Inc., AMAP is the physicians' answer to both multiple and duplicative reviews and evaluation by non-physicians.

Health Affairs has published a review of information privacy issues. Janlori Goldman, JD, of Georgetown University observes, "Without trust that the personal, sensitive information that they share with their doctors will be handled with some degree of confidentiality, patients will not fully participate in their own health care." The patients won't tell their histories, describe their concerns, or admit to other therapies.

Goldman advocates a "two-tier" system. On one-tier physicians, reviewers, and payers share access to information about the patient that is necessary to determine treatment and payment. On the other tier, the patient must specifically consent to disclosure for most other purposes.

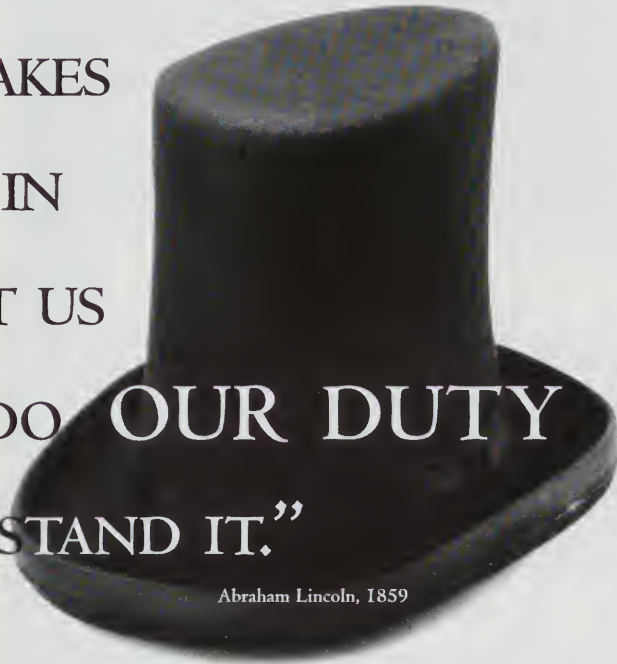
Note that the privacy issue is part of the patient bill of rights debate. The Republican measure passed by the House of Representatives in August would preempt state protections and require broad disclosure to payment reviewers.

Information is vulnerable to the great bug of Y2K. Testifying before the Senate Special Committee on the Year 2000, the Gartner Group's Lou Marcoccio said physician practices are "extremely behind" other enterprises in coming to grips with the problem. *Medicine & Health* suggests that few practices appear to have called in consultants to reduce exposure to possible system failures.

Health & Senior Services Commissioner Len Fishman continues to make progress in his efforts to minimize the certificate-of-need (CN) process. The law firm of Brach, Eichler, and others notes that linear acceleration and positron emission tomography will join extracorporeal shock wave lithotripsy, ambulatory surgical facilities, and replacement of major moveable equipment as services that no longer require CNs.

Negatively charged communication is nothing new. James Madison wrote in the Federalist papers that "differences of mere opinion" can cause social disintegration when "people focus only on the differences and demonize those who disagree with them." Happy holidays to all.

“LET US HAVE FAITH
THAT RIGHT MAKES
MIGHT, AND IN
THAT FAITH LET US
DARE TO DO OUR DUTY
AS WE UNDERSTAND IT.”



Abraham Lincoln, 1859

Setting rates is one of the most challenging tasks an insurer faces. At Princeton, we balance doctors' desire for low-cost professional liability insurance protection with the need to bring in sufficient funds to pay claims. Responsible rate setting, including savings for doctors with good claims experience, is in line with our longstanding commitment (one score and counting) to serve policyholders this century and beyond.

For a policy that delivers value in return for your hard-earned premium dollars (and cents), consult one of the independent agents who represent Princeton or call us at **1-800-433-0157**.



Princeton Insurance Company

Professional Liability

Office Package Policy

Workers Compensation

Rated A- (Excellent) by A.M. Best Company 746 Alexander Road • Princeton, New Jersey 08540

POLAR GRIZZLY TEDDY

Best wishes for the happiest holidays
and a New Year filled with joy,
success and peace.



THREE BEARS

ADVERTISING • MARKETING COMMUNICATIONS

20 NASSAU STREET, PRINCETON, NJ 08542
609-688-1400

New Jersey Medicine (ISSN-088-5842-X) is published monthly (since 1904) under the direction of the Council on Communications by the Medical Society of New Jersey (MSNJ), Two Princess Road, Lawrenceville, NJ 08648. Printed in Lancaster, PA, by Lancaster Press. Printed in USA. Whole number of issues 1134. Member's subscription (\$10) is included in MSNJ dues. Rates for nonmembers are \$50; outside USA, add \$20. Single copy is \$7.50. Periodicals postage paid at Trenton, NJ, and Lancaster, PA. Copyright 1998 by MSNJ. December 1998. Internet address: <http://www.msnj.org>. E-mail address: info@msnj.org. 609.896.1766. FAX 609.896.1368. Postmaster: Send address changes to *New Jersey Medicine*, Two Princess Road, Lawrenceville, NJ 08648. The appearance of advertising *New Jersey Medicine* is not a MSNJ guarantee or endorsement of the product or service, by the advertiser. When MSNJ has endorsed a product or program, that will be expressly noted.

NEW JERSEY MEDICINE

DECEMBER 1998

Editor-in-Chief Howard D. Slobodien, MD
Executive Editor Geraldine R. Hutner, MA
Assistant Editor Nancy M. Propsner, BA
Editorial Assistant Karen Cuozzo, BS
Advertising Cookson Media Services
Ritchie Resource Group
Production Trenttypo, Inc.
Graphic Design Three Bears Communications
Cover Conrad Gloos

President and Choir R. Gregory Sachs, MD
President-Elect Irving P. Ratner, MD
First Vice-President Walter J. Kahn, MD
Second Vice-President Angelo S. Agro, MD
Secretary Bessie M. Sullivan, MD
Treasurer Eileen M. Moynihan, MD
Immediate Post-President Carl Restivo, Jr, MD

MEDICAL SOCIETY OF NEW JERSEY BOARD OF TRUSTEES

S. Manzoor Abidi, MD
Stevan Adler, MD
Churchill L. Blakey, MD
Donald J. Cinotti, MD
Rajendra Prasad Gupta, MD
George T. Hare, MD
David A. Ingis, MD
Philip J. Jasper, MD
Elliot M. Kraus, MD
Giovanni Lima, MD
Mark T. Olesnick, MD
Robert S. Rigolosi, MD
Andrew Kunish, MD, *Speaker of the House*
John W. Spurlock, MD, *Vice-Speaker of the House*
Francis J. Lumia, MD, OMSS
Jamsheed K. Najmi, MD, *Medical Specialty Societies*
Sean C. Reinhardt, *Medical Student*
Niranjan V. Rao, MD, *Member-at-Large*
Michael J. Spedick, MD, *Member-at-Large*
Valerie Claps, *MSNJ Alliance*
Carlo Porcaro, MD, *IMG Section*

COUNCIL ON COMMUNICATIONS

Charles M. Moss, MD, Chair, Harry M. Carnes, MD, Vice-chair,
Henry R. Liss, MD, Vice-chair, Richard M. Ball, MD,
John P. Capelli, MD, Paul J. Carniol, MD,
Andrew B. Covit, MD, Anthony Del Gaizo, MD,
Joseph A. Di Lallo, MD, Michael J. Doyle, MD,
Leigh Ende, MD, Steven C. Fiske, MD,
Jack Goldberg, MD, Daniel P. Greenfield, MD, MPH,
George H. Hansen, MD, M. Arif Hashmi, MD,
Christine E. Haycock, MD, Neil B. Horner, MD,
Monroe S. Karetzky, MD, Ismail Kazem, MD,
Louis L. Keeler, MD, Scott P. Keil, MD,
Joseph W. Kozielski, MD, Clement H. Kreider, Jr, MD,
Alan J. Lippman, MD, Robert M. MacMillan, MD,
George J. Mellendick, MD, MPH, Donald W. Orth, MD,
Robert M. Pallay, MD, Sindy M. Paul, MD,
Arthur W. Perry, MD, Niranjan V. Rao, MD,
Kelly M. Reid, MD, Carl Restivo, Jr, MD,
John D. Slade, MD, Leon G. Smith, MD,
Julie E.K. Timins, MD, Sandra S. Valdez, MD,
Paul E. Wallner, DO, Richard A. Williams, MD,
Angelina Campo, Angelo S. Agro, MD,
Irving P. Ratner, MD, Howard D. Slobodien, MD,
Matthew J. Stanton, Bessie M. Sullivan, MD

Medical Humanities Program



In the Medical Humanities Program at Drew University, health care providers explore issues ranging from medical insurance, genetic engineering, and abortion to euthanasia, medical malpractice and alternative therapies using the accumulated knowledge and wisdom of the humanities. The program is conducted jointly by Drew and The Raritan Bay Medical Center, an affiliate of Robert Wood Johnson University Hospital.

- Certificate and Master's programs
- Clinical practicum conducted at Raritan Bay Medical Center.

Courses include:

- Biomedical Ethics • Clinical Ethics
- Coping & the Caregiver • Great Issues in Medicine
- Family Dynamics • History of Biomedical Science
- Literary Art and the Medical Mind

For information call the
Graduate Admissions Office
at 973/408-3110

DREW

DREW UNIVERSITY • MADISON, NEW JERSEY 07940

YOU PRACTICE I'LL REORGANIZE YOUR EXISTING OFFICE



Is your staff working up to its potential? Is your office operating efficiently? Are your codes current? If not, consider the turn-key method. Mary Ann Hamburger has triumphed as the most comprehensive and diverse single source for medical office set ups and reorganizations. She is an expert in every detail of office administration. Mary Ann will reorganize and reenergize your present office. She can guide you in establishing the fee schedules appropriate to your specialty, geographic area and current market. She'll train your staff in scheduling properly to insure effective patient flow. An expert in CPT and ICD codes, Mary Ann Hamburger will update them yearly to insure proper reimbursement. For a whole new approach to medical office practice, call today.

MARY ANN HAMBURGER

A S S O C I A T E S

THE SPECIALIST'S SPECIALIST

74 HUDSON AVE. MAPLEWOOD, N.J. 07040
201-763-7394

NEW JERSEY RESIDENTS: DOUBLE-TAX-FREE INCOME

100% NO LOAD

**YIELDS
6.78%**

Tax-equivalent
36% tax rate

4.06%

Current
30-day yield
as of 10/31/98

T. Rowe Price New Jersey Tax-Free Bond Fund is ranked #2 out of 16 funds in the Lipper New Jersey Municipal Debt Category since its inception (4/30/91) for the period ending 9/30/98.* This fund invests primarily in long-term New Jersey municipal securities, so the income it offers is double-tax-free. *You pay no state or federal tax on your investment earnings.*** Proprietary credit analysis and active management help reduce risk. Of course, the fund's yield and share price will fluctuate as interest rates change.

With no sales charges, all your money works for you. The fund is 100% no load. And, since there are no broker fees—which can eat up as much as 5% of your principal—all your money gets invested. \$2,500 minimum. Free checkwriting.†

**Call 24 hours for your
free investment kit
including a prospectus
1-800-541-4626
www.troweprice.com**

Invest With Confidence®
T. Rowe Price



14%, 5.78%, and 8.06% are the fund's 1-year, 5-year, and since inception (4/30/91) average annual total returns, respectively, for the periods ended 9/30/98. Figures include changes in principal value, reinvested dividends, and capital gain distributions. Investment return and principal value will vary, and shares may be worth more or less at redemption than at original purchase. *According to Lipper Analytical Services, Inc., which ranked T. Rowe Price New Jersey Tax-Free Bond Fund #7 out of 58 for the 1-year period ended 9/30/98. **Some income may be subject to the federal alternative minimum tax. Income earned by non-New Jersey residents will be subject to applicable state and local taxes. †\$2,500 minimum. Past performance cannot guarantee future results.

Read the prospectus carefully before investing. T. Rowe Price Investment Services, Inc., Distributor.

NJB045369

26

Focus on health care

People of the year

By Bill Berlin, PhD

New Jersey Medicine bestows accolades on the co-winners of the 1998 People of the Year Award. The honors go to Dr. Hait and Gov. Whitman and their tremendous impact on health care.

31

Special feature

In pursuit of information: Quality care

By Flora Davis

Now more than ever, we need objective ways to measure the quality of health care. This is an achievable goal for all New Jersey residents and for all Americans.

37

Public health advances

Fighting food-borne illnesses

By Robin K. Levinson

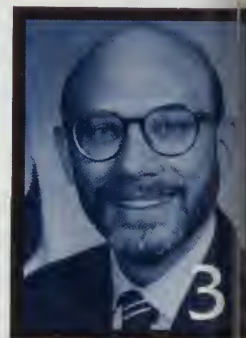
Food-borne infections are common, and food-borne diseases kill over 9,100 people every year. Steps can be taken to prevent outbreaks and to treat patients.



Howard Slobodien, MD
on the end of an era.



Julane Miller
on healthy lifestyles.



Len Fishman
on quality care.

Critical Treatment for the Future of Your Practice...



Before It's Too Late

Wilentz, Goldman & Spitzer's Health Care Law Practice Group serves health care professionals regarding: group practice formation and operations; management service organizations (MSOs); physician practice management companies (PPMCs); managed care contracting; physician-hospital organizations (PHOs); independent

physician associations (IPAs); restrictive covenants; and regulatory, employment, tax and litigation matters. **Think of us as preventive medicine for your practice.** For information please call our Health Care Law Practice Group Co-Chairs: Michael F. Schaff at (732) 855-6047 or Francis V. Bonello at (732) 389-5636.

**WILENTZ
GOLDMAN
& SPITZER**
ATTORNEYS AT LAW

"Helping The Health Care Professional"

Woodbridge, NJ • Eatontown, NJ • New York, NY

<http://www.newjerseylaw.com>

41 **Commentary** **New Jersey hospitals achieve magnet status**

By Marguerite K. Schlag, RN, MSN, EdD

The level of excellence in nursing services and care at the institutional level is noted and honored by the ANCC Recognition Program.



Hackensack University Medical Center's Magnet Nurse champions move nursing care to a new level of excellence.

46 **Current trends** **Whatever happened to mental health?**

By Bill Berlin, PhD

In managed care's ongoing struggle to control health care costs, coverage for mental health has been the biggest casualty.

51 **Law, medicine & ethics** **Whom to believe? A review of recent malpractice cases**

By Neil E. Weisfeld

Consider the realm of medical malpractice cases recently tried in New Jersey. Take a look at a few instances where credibility counted.

DEPARTMENTS

1 **Newswatch**

Communication in the 90s. Changing the method or the message. Y2K issues in medicine.

10 **Mail Stop**

Warfarin therapy. Vaccination rates for a New Jersey hospital.

15 **Editor's Notes**

The value of autopsies. Needle-exchange programs and AIDS. A fond farewell.

18 **Online@MSNJ**

Searching the Internet. A new mouse. New Jersey is a winner. Good food on the net.

20 **F.Y.I.**

A time to share. Protect their bones. New Year's resolutions. Putting children first.

24 **MSNJ News**

Celebrating its 150th anniversary, Mercer County Medical Society has made its mark in medicine.

56 **Calendar**

Current listing of medical meetings and conferences around the state this winter.

64 **Photo Finish**

Ellen Leavell, MD, from St. Peter's University Hospital and Health System collects her thoughts.

Medical Society of New Jersey

Long Term Care Insurance Program

Ensuring a Secure Future by Preserving Assets

As medical professionals, you know first hand the devastating effects that extended long term care can have on a person's hard earned assets. The cost of nursing home stays can range from \$3,000-\$5,000 per month. The Medical Society of New Jersey endorses The Travelers and CNA Insurance Companies' policies to help you guard against unforeseen tragedies. Through a special arrangement with The Travelers and CNA Insurance Companies, members, spouses, parents and in-laws are eligible for a premium reduction.

IMPORTANT FEATURES OF THE MSNJ ENDORSED LONG TERM CARE INSURANCE PROGRAM

- ◆ Available Ages 45-84
- ◆ Specialty Plans Available Ages 80-100
- ◆ Benefits up to \$250/day
- ◆ No prior hospitalization required
- ◆ Several waiting periods
- ◆ Alzheimer's, senility covered
- ◆ Lifetime benefits available
- ◆ Guaranteed renewable for life
- ◆ Coverage for custodial, skilled and intermediate care as well as adult day care
- ◆ Available to your spouse, parents and in-laws
- ◆ Waiver of premium benefit
- ◆ Inflation protection available

DISCOUNT FOR MEMBERS OF MSNJ, SPOUSES, PARENTS AND IN-LAWS

For more information, please call

DONALD F. SMITH & ASSOCIATES

A division of THE COPELAND COMPANIES[®]

Two Tower Center, P.O. Box 1063
East Brunswick, New Jersey 08816-1063

(888) 297-7225

Copeland Associates, Inc.

Medical Society of New Jersey
MSNJ

Warfarin therapy

The initiation of chronic anticoagulation is begun in a hospital setting with recommendations to begin heparin and warfarin on day one. Following administration of warfarin, an observable anticoagulation effect is delayed until newly synthesized dysfunctional vitamin K-dependent clotting factors replace the normal clotting factors as the latter are cleared from the circulation. Depending on the dose administered, the delay may range from two to seven days. Heparin, therefore, is maintained for the first five days until a therapeutic level of warfarin can be obtained. To the best of our knowledge, there are no guidelines for obtaining INRs in the initiation of warfarin therapy.

A retrospective study was undertaken reviewing all admissions over a one-year period of patients newly started on warfarin. Patients then were classified as to how quickly they became therapeutic. Comparisons of each group were done to ascertain the necessity of daily INRs and if certain patient characteristics or dosing regimens were predictive of when they were expected to become therapeutic. Of the 55 patients in the study, no patient

became therapeutic after one 10 mg dose of warfarin. Thirteen patients became therapeutic after two days of warfarin (group 1), 15 patients became therapeutic after three days (group 2), 14 patients became therapeutic after four or five days of warfarin therapy (group 3), and 13 patients required greater than five days (group 4) to acquire a therapeutic INR. During the initial five days of this study there were no complications of bleeding, skin necrosis, or death reported.

Statistical analysis was performed to determine if any significant differences were found between groups. There was no significant difference between sex of patients and when they became therapeutic. There was no statistically ($q=2.44$) significant difference between age or weight ($q=3.56$) of the patients when comparing group 1 to group 4, however, definite trends were found (74.4 years old in group 1 compared to 63.9 years average age in group 4 and a weight difference

of 66.8 kg in group 1 compared to 85.6 kg in group 4).

Although there are standardized reasons for chronic anticoagulation (as well as for dosing heparin), there is no standardization for dosing and predicting the INR effectively in the initiation of warfarin. This study was designed to check the efficacy of following daily INRs in the hospital setting. We found that no patients became therapeutic or had complications after one day of warfarin (maximum dose 10 mg). Only 24 percent became therapeutic after day two of warfarin dosing. Twenty-eight of 55 patients were therapeutic after day three. Twenty-seven of 55 patients (49 percent) required more than three days to become therapeutic. Of our patients, 87 percent had no dosing changes between day one and two. During the first five days of this study, there were no complications. Statistical analysis of subgroups revealed a trend toward weight dosing (similar to heparin)

and a trend toward dosing adjustment for age. This study was retrospective; therefore, not all data were available for all patients and rationale could not be specifically determined from the chart of daily warfarin dosing. We feel, however, that it is not necessary to check INRs after day one of

POSITION AVAILABLE: EDITOR-IN-CHIEF

The Medical Society of New Jersey (MSNJ) announces the position of Editor-in-Chief of its monthly print organ, *New Jersey Medicine (NJM)*. MSNJ's Strategic Plan (1995) includes an objective to "advance [NJM] as the major health policy publication in New Jersey and expand its readership beyond the membership and physician community."

The part-time position includes control of the peer review process, furnishing of an assigned or personally drafted monthly editorial, and participation in decisions about commissioned pieces, editorial format, design, advertising, circulation, and activities of the *NJM* Review Board and the MSNJ Council on Communications.

MSNJ members interested in the position are invited to submit a hard-copy resume and cover letter directed to the attention of Ms. Diana C. Gore, Director-Officer Services, at MSNJ, 2 Princess Road, Lawrenceville, NJ 08648, before January 15, 1999. They should emphasize either in their resume or the cover letter their scientific publication experience.

YOUR PRACTICE HAS CHANGED SIGNIFICANTLY. SO WHY HASN'T YOUR PRACTICE INSURANCE?

Traditional policies for medical practices are not tailored for you. In fact, the same insurance policy you currently use covers everything from a shoe store to a pizza parlor. Does that sound logical?

The Woodland Group has changed the concept of insuring a medical practice. Today, your medical practice can be protected by The Woodland Alliance Profile, a Risk Management Group created exclusively for physicians offering . . .

- Practice-specific coverage that has and will continue to evolve as the medical industry changes, covering everything from office property and patient charts to diagnostic equipment, general liability and workers' compensation.
- An opportunity to share in profitability of the Risk Management Group through profit sharing returns.

Put Yourself in the Hands of a Specialist.

Call us at **1-800-253-1521** to learn more about The Woodland Alliance Profile or check our website at **www.woodlandgroup.com**.

***The Woodland Alliance Profile...
coverage that is as evolutionary
as your practice.***



- Medical Malpractice
- Managed Care Liability
- Group Disability
- Group Term Life
- Homeowners/
Automobile

1-800-253-1521
<http://www.woodlandgroup.com>



warfarin initiation, which would lead to cost savings.

Though there are trends with regard to age and weight, a prospective study will be necessary to further define the necessity of daily INRs on successive days as well as standardization of dose.

Charles Spellman, DO

Kenneth M. Granet, MD

Minnie Kurian

Long Branch

Vaccination rates

New Jersey's immunization rates for older adults are among the lowest in the nation. An estimated 16 percent of people age 65 and older have received pneumococcal vaccine. This number is well below the *Healthy People 2000* immunization goal of 60 to 80 percent.

We generated a list of 102 patients who were seen at Monmouth Medical Center in the 12 months prior to and including May 31, 1998. A single physician reviewed medical records. This same reviewer conducted telephone surveys with the patients to confirm their vaccination status and to elicit the top reason from each non-vaccinated person for not being immunized. Only those patients who had chart reviews and who were personally contacted were included for analysis.

Of 94 patients, 30 percent had received the pneumococcal vaccine, while 64 patients (68 percent) had not. Among the 64 non-vaccinated persons, 33 (52 percent) had other medical conditions where the vaccine would have been indicated regardless of age. The reasons among the 64 unvaccinated persons for not being immunized were: "denied being informed or unaware of the vaccine" in 42 patients (66 percent); "refused" in 18 patients (28 percent); and "transportation to the facility" issues in 4 patients (6 percent).

Physicians are a source of patient information, and prior studies have shown that provider lack of knowledge about the pneumovax guideline was one reason for patients being uninformed and for low vaccination rates. We have implemented physician lectures and chart reminders and have posted fliers about the indications for the vaccination in examination and charting rooms throughout Monmouth Medical Center. Medical residents are performing peer review on each other's charts, and the pneumovax compliance rates are being monitored. We also have sent reminders to physicians and nurses to ask when they are giving the influenza vaccine, because these vaccines can be administered

simultaneously and physicians may be more familiar with the influenza guidelines. Posters and pamphlets for patient education have been displayed throughout our waiting area and at the registration desk.

Because this study involves only those in contact with our facility, it does not reveal the true pneumovax rate for the whole community. It is likely that our study underestimates this rate, and that there are many people with "transportation issues" who do not have access to a health care provider or medical information. Monmouth Medical Center is forging relationships with the local housing authority, senior citizen centers, and religious organizations to provide information and outreach workers to the community. We have a grant-funded social worker, a health educator, and a physician's assistant who will help get information or even supply the vaccine to those patients who are unable to access care. Other statewide initiatives are needed to help supplement the educational, clinical practice, and outreach strategies that we have employed, so that rates can reach or exceed published targets.

Todd Gruber, MD, MPH

Kimberly Hightower, MD

Rao Marada, MD

Long Branch

Kessler Continuing Medical Education

- ♦ Career advancement and development
- ♦ Review courses for board certification
- ♦ Continuing medical education

Mark your calendar for these upcoming programs...

January 22, 1999	Evoked Potentials/Intraoperative Monitoring
February 5 & 6, 1999	8th Annual Basic & Advanced Prosthetics & Orthotics: <i>Lower Extremity</i>
March 5-14, 1999	11th Annual Review Course In Physical Medicine & Rehabilitation*
August 25-30, 1999	4th Annual Manual Medicine Course (Basic August 25, 26, 27...Advanced August 28, 29, 30)

Kessler Medical Rehabilitation Research & Education Corporation (KMRREC) continues the tradition and promise of programs that deliver. Whether you are looking for career advancement and development, review for board certification or continuing medical education...please note the above dates and call for a brochure...
800-248-3221 ext. 6812.

What: *Continuing Medical Education Courses*

When: *Please note dates above*

Where: *Kessler Conference Center, West Orange, New Jersey (unless otherwise specified on course brochures)*

Speakers: *World renowned speakers, and faculty from UMDNJ - New Jersey Medical School*

Who should attend: *Resident or attending, as well as private practice physicians*

Sponsored by: *Kessler Medical Rehabilitation Research and Education Corporation (KMRREC)*



KMRREC Education

Kessler Medical Rehabilitation Research & Education Corporation
1199 Pleasant Valley Way - West Orange, New Jersey 07052

* The 11th Annual Kessler Review Course in PM&R is sponsored by KMRREC and the Department of PM&R - UMDNJ-New Jersey Medical School. This course will be held at the Ramada Inn & Conference Center, East Hanover, New Jersey. Visit **KMRREC** at www.kmrrec.org.

Our medical specialists make a practice of creating solutions for physicians like you.

Summit Bank's Healthcare Financial Services Group features some of the finest medical specialists in New Jersey. They understand your industry and the issues facing it. As New Jersey's largest locally headquartered bank, our professionals are specifically devoted to the healthcare industry. That means our customized solutions — from loans to leases — come with something extra: time-tested expertise. If you'd like, we'll even help you find a more efficient way to run your practice. To find out more, call Norm Buttaci, Regional Vice President, 609-987-3561.



Summit, Summit Bancorp and Reach Higher are registered service marks of Summit Bancorp • Summit Bank is a service mark of Summit Bancorp.

End of the year accounting

The CBS program *60 Minutes* televised "Autopsy" on Sunday, October 11, 1998. The broadcast properly identified the continually falling autopsy rate in this country as a problem. CBS was not content to indicate the need for change. It imputed dishonorable and mercenary behavior as the underpinning for the paucity of autopsies. It suggested physicians and hospitals want to suppress autopsies to avoid malpractice actions, and that risk managers act as bereavement counselors and dissuade families from having postmortem examinations.

The erstwhile prudent, non-practicing pathologist-editor of *The Journal of the American Medical Society (JAMA)* unfortunately encouraged this approach. It was bad enough that Dr. Lundberg said hospitals were burying their mistakes "in large numbers." It was worse when he said, "Some doctors, some medical staffs are afraid to find out what happened to people who died." It became unconscionable when he said,

"Risk management, in many institutions in this country, is designed to suppress truth."

Leilani Kicklighter, American Society for Healthcare Risk Management (ASHRM) president, noted that bereavement counseling violates ASHRM's Code of Professional Responsibility and that accusing them of conspiring to suppress information is both "inaccurate and irresponsible." Jonathan

Howard D. Slobodien, MD



Great things
are believed
of those
who are
absent.

Tacitus, *Histories*, 104-109

T. Lord, MD, CEO of the American Hospital Association agreed that more autopsies would be of value, but assured the public that quality assurance programs were "extensive and thorough." Randolph D. Smoak, MD, chair of the Board of Trustees of the AMA, emphasized that "physicians are more interested than anyone else in determining the true cause of death. It's irresponsible and unsup-

ported to assert that malpractice is the reason the rate of autopsies is declining."

The decline of the autopsy rate is due to the changing standards of JCAH, later JCAHO. In 1965, the post-mortem requirements for hospitals was 20 percent for community hospitals and 25 percent for teaching hospitals. This standard was dropped in 1970. Autopsy findings now are a required source for quality assessment and improvement activities. In 1999, JCAHO will allow an organization to make its own decisions about which data, including autopsy findings, it deems necessary for quality control.

Payment is another major factor. The true cost of autop-

Editor's Notes

sies is not reimbursed. Smoak noted this, as did Thomas P. Wood, MD, president of the College of American Pathologists. The chief pathologist at one of my local hospitals estimates that an increase in the autopsy rate to 20 percent would require the services of at least one additional full-time pathologist, and the money for this would not be available.

If the autopsy rate is to increase, standards and payments must lead the way. In the interim, the accusations of CBS and of Dr. Lundberg serve only to confuse and alarm unnecessarily. Sir Robin Day expressed it well in the November 8, 1989, issue of the *Financial Times*: "Television thrives on unreason, and unreason thrives on television. It strikes at the emotions rather than the intellect."

This October two new members were appointed to the Governor's Advisory Council on AIDS, to replace some who died of AIDS. Both feel that the only sensible approach to AIDS is chastity. One, a Glen Rock chiropractor, is the New Jersey director of Concerned Women for America (CWA). Tia Swanson described these appointments in her *Home News Tribune* column of October 21. She portrays the CWA as a group that sees immorality in almost everything. More importantly, "CWA also asserts that health officials have

Truth has
a handsome
countenance
but torn
garments.

German proverb

overplayed the AIDS risk, that the only people who really have to worry are gays, drug addicts, and those who have sex with them."

It should not be necessary to rehash the overwhelming scientific evidence supporting the value of exchange programs. Shall we ever treat AIDS properly as a public health problem? Is it moral to abandon chemically dependent people because they have not yet decided to adopt our lifestyles?

Congratulations to the 1998 People of the Year: Governor Christine Todd Whitman and William N. Hait, MD, PhD. They have contributed mightily to the health and welfare of all of us and they deserve our heartfelt appreciation.

Finally, with regret, I have tendered my resignation as editor-in-chief of *New Jersey Medicine*. It is time for someone with younger ideas to assume the position. I never expected, in spring 1988, to last this long. But the pleasures it has given me have sustained me and the memo-

ries will continue to do so, as my wife and I devote more time to other pursuits, including quality time with grandchildren.

There are many who have helped me during these years, when *New Jersey Medicine* changed from a house organ to a health policy magazine for the state. The staff at MSNJ is incomparable, but I have known that for decades. The members of the Review Board constitute a class act that would be difficult, nay impossible, to surpass. The members of the Council on Communication have done yeoman service including chairs Henry Liss, MD; Harry Carnes, MD; and Charles Moss, MD. Joe Cookson has aided us more than in just advertising and budgeting. Karen Cuozzo, the newest member of the staff, has proved a welcome and helpful addition. Nancy Propsner is a valuable assistant editor. And Gerri Hutner. She is the heart and soul of the operation. I honestly do not understand how she can juggle so many duties and do them all so incredibly well. Thank you Gerri, and all those who have contributed so nobly. And thank you, *New Jersey Medicine* readers. I hope I have been of service. If we have crossed swords at times, it was a duel done in friendship. So Godspeed and *au revoir*.

Happy holidays and a happy, healthy New Year.

We know that practicing medicine is your primary concern.

The professionals at Healthcare Management Partners will take away the time-consuming administration and pressures of billing, collections, follow-up, office management, and system maintenance, so you can concentrate on doing what you do best - practicing medicine.

Contact Rosalie Fox or Robert Rahl at 609-734-0443 to find out more.

**Practice Assessments • Billing & Collection •
MIS Systems • Group Practice Formation •
Practice Management • Income Distribution**

**Endorsed Computerized Billing,
Accounts Receivable and
Information Management Company of the
Medical Society of New Jersey**



HEALTHCARE MANAGEMENT PARTNERS

PARTNERS IN PROFIT

200 Canal Pointe Boulevard • Princeton, NJ 08540-5998
609-734-0443 • FAX 609-243-9799

A Division of Health Information Consulting Services, Inc.

HANDS OFF

Now you have a choice. Use the traditional desktop mouse or the innovative foot-controlled mouse. The NoHands Mouse (www.footmouse.com) eliminates repetitive "key-board-to-mouse" hand move-



ments, gives you complete control of the cursor without taking your hands

off the keyboard or your eyes off the monitor, and improves your input and typing productivity. And an added benefit is that this mouse safeguards against repetitive stress injuries, including carpal tunnel syndrome, to the hands and wrists.

SEARCHING MADE EASY

There's plenty of information online, but which search engine should you try? Alta Vista, Excite, and Lycos use software that search the Internet and create an index of sites based on the words in the site. Yahoo is another type of search engine, called a directory, which is not as comprehensive. Yahoo is helpful for popular information. For harder to find or more comprehensive, up-to-date information, use major

search engines like Alta Visa, Excite, HotBot, Infoseek, Lycos, and Northern Light. For more effective results, try the search on different search engines and become familiar with the Boolean technique for specific search engines. Happy searching out there.

NEW JERSEY HAS A WINNER

Trenton ranks number one. It's the best medium-size town in the Northeast to live, says *Money* magazine in its 12th annual ranking of the best places to live in America. Its favorable position near New York City and Philadelphia, notes *Money* magazine, adds to its attractiveness. Other region winners are: Madison, Wisconsin (Midwest); Boulder, Colorado (West); and Richmond, Virginia (South). Check out the details at: <http://pathfinder.com/money/bestplace/index.html>.

GOOD FOOD

Looking for a new restaurant? Find the perfect one at New Jersey Online (www.nj.com). This site lists over 3,500 New Jersey restaurants; you can search for places to eat by cuisine, price range, and location. Get the latest restaurant reviews. Or if cooking is your favorite pastime, you can choose from over 7,500 recipes. Bon appetit.

BOOKMARKS

www.m-w.com

Merrian-Webster offers medical-related electronic reference products and dictionaries. Also check out the Stedman's line of electronic medical dictionaries and spellcheckers (www.stedmans.com) from Lippincott Williams & Wilkins.

www.state.nj.us/health

Your "A to Z" guide on how to choose a long-term care facility. Maintained by the New Jersey Department of Health and Senior Services, the section also contains a county-by-county directory of facilities.

www.ahd.com

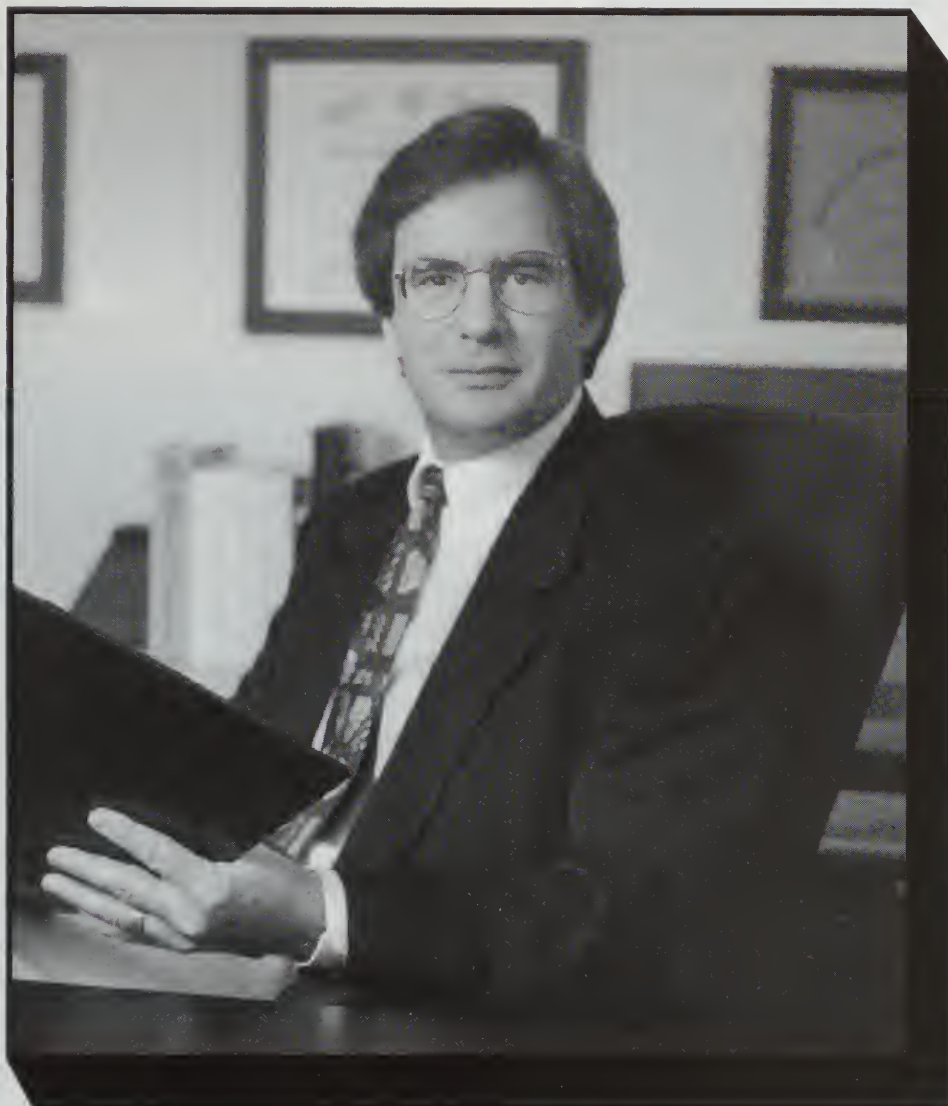
Access basic information about hospitals across America including financial status, average lengths-of-stay, and services provided.

www.njshc.org

Find a self-help group—or get help starting one—at the New Jersey Self-Help Clearinghouse web site.

www.hinj.org

Just how far-reaching is New Jersey's pharmaceutical industry? Check out the HealthCare Institute of New Jersey's online survey.



Stuart M. Hochron, M.D., Esq.

Physician Legal Representation

- Group Practice Formation
- Physician Litigation
- Federal Regulation
- Board of Medical Examiners

Practicing Physician, Twenty Years

Clinical Professor, UMDNJ-RWJMS

Research as Highlighted on CNN

AMA Physician Referral Service

Partner, Richmond, Hochron & Burns



phone: (732) 821-0200 fax: (732) 422-9444 e-mail: MDLAWSMH@aol.com

209 North Center Drive North Brunswick, New Jersey 08902

A TIME TO SHARE

The New Jersey Organ & Tissue Sharing Network, the state's organ

procurement organization, has published a new donor registry brochure, "Give the Gift of a Lifetime."

Upon request, a supply will be sent to New Jersey physicians for placement in waiting rooms and reception areas with-

in the workplace. To receive a supply, please call 973.379.4545.

PROTECT THEIR BONES

The Osteoporosis Coalition of New Jersey and the New Jersey Department of Health and Senior Services have published recommended practice guidelines for the diagnosis and treatment of osteoporosis. In a nutshell, the guidelines follow these rules: PROTECT. P: Prevent. R: Risk Assessment. O: Observe. T: Test. E: Explain. C: Conservative Measure. T: Treat Aggressively. As stated in its introduction, with the distribution of these recommended guidelines, it is the earnest hope that the prevention, recognition, and treatment of osteoporosis in New Jersey will become a routine practice.

New Year's Resolution: If New Jersey residents make one positive healthy lifestyle change for 1999, what should it be?

Respect of the body and mind: eating healthy, living healthy, behaving healthy, and avoiding unhealthy risks.

Ismail Kazem, MD
MSNJ Council on Communications

Moderation in lifestyle: avoiding drugs, smoking, and excessive eating, or alcoholic consumption.

Stuart Cook, MD
Acting President, UMDNJ

Change of mindset is my wish: everyone must become their own best advocate for the services, information, care, and insurance coverage they will need to maintain a healthy lifestyle.

Carol J. Kientz, RN, MS
Executive Director, Home Health Assembly of NJ

Get more exercise. Do as I say, not as I do!

Michael R. McGarvey, President
Horizon BlueCross BlueShield of New Jersey

Disease prevention and health maintenance start with an educated and motivated consumer. Educate. Promote personal responsibility. Engage and include. Empower.

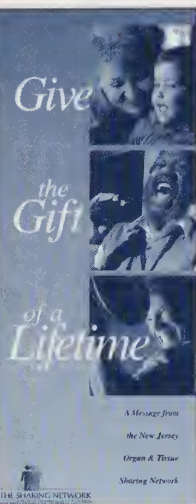
Julane Miller, Executive Director
Plainfield Health Center

It's always easier to stay well than it is to get well. A 20-minute walk three times a week is a great first step toward good health.

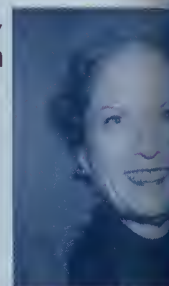
William H. Treymane, President
HealthCare Institute of New Jersey

I resolve to share in the larger labors of MSNJ, to define, preserve, and protect the sanctity of the physician-patient relationship and the duties, obligations, and rights subsumed in this ancient trust.

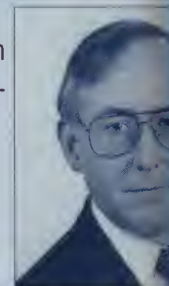
Paul W. Armstrong, Esq
Kern Augustine Conroy & Schoppmann, PC



Stuart Cook, MD



Carol J. Kientz, RN, MS



Michael R. McGarvey



Julane Miller



Horizon Blue Cross Blue Shield
of New Jersey

*Making Healthcare Work*SM



Making Healthcare Work

Blue Cross and Blue Shield of New Jersey is now Horizon Blue Cross Blue Shield of New Jersey. Count on us to make health care work for you and your employees.

With our affordable health care plans, your employees can:

- Visit a specialist without a referral through our new Horizon Direct Access health plan.
- Receive nationwide access to over 560,000 participating doctors, specialists and hospitals.
- Receive value added discounts from Cole Vision, IBM, Modell's, Gold's Gym, and CompUSA.

And, announcing a \$25,000 life insurance program. (Free to MSNJ members enrolling with Horizon Blue Cross Blue Shield of New Jersey.)

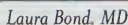
This and more is available when you choose a health plan from Horizon Blue Cross Blue Shield of New Jersey — the Medical Society of New Jersey's health carrier of choice for its members.

For more information contact:

Jennifer Altobelli
Sales Representative
973-338-0893

Medical Society of New Jersey
MSNJ

PUTTING CHILDREN FIRST

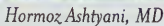


Parents always can use support in raising children. Doctors can offer a resource guide for parents, *Families in Focus: Parent Resource Guide*. The guide, part of the New Jersey Caucus Families in Focus series, is intended to offer today's parents real solutions to the challenges of raising children in the 90s. The guide covers health, education, recreation, children with special needs, child care, and support groups. It also

contains parenting tips and where to turn for assistance. The publication is produced by the Caucus Education Corporation and the Association for Children of New Jersey. For a copy of the booklet, contact the Caucus Education Corporation at 566.0050.



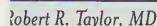
Neil E. Weisfeld, JD, deputy executive director of the Medical Society of New Jersey, has been elected chair of the Board of Trustees of Trenton Psychiatric Hospital; TPH received accreditation with commendation from the Joint Commission on Accreditation in its last survey.



MSNJ member **Arnold Derman, MD**, has

been appointed to the UMDNJ Board of Trustees.

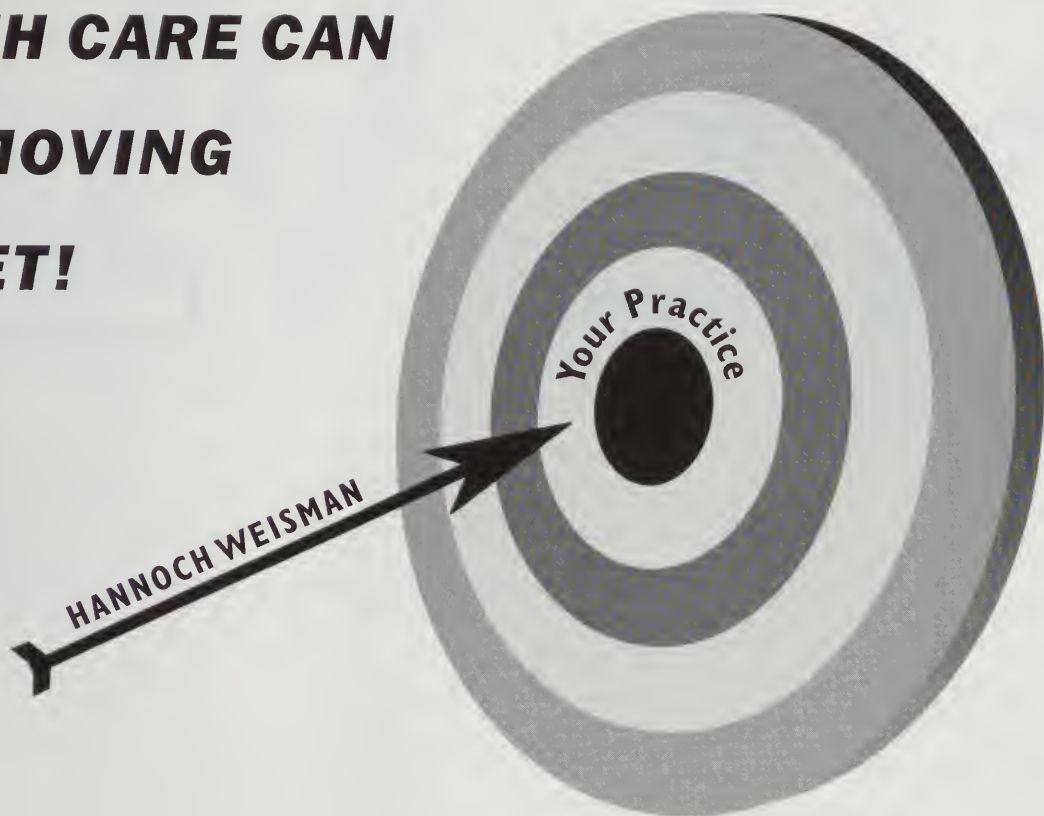
Michael B. Greene, PhD, has been named the executive director of the UMDNJ Violence Institute of New Jersey.



Center as associate director of the
Division of Gynecologic Oncology.



HEALTH CARE CAN BE A MOVING TARGET!



WHEN YOU CAN'T AFFORD TO MISS . . .

HANNOCH WEISMAN HAS A RECORD OF HITTING THE MARK WHEN ADVISING PHYSICIANS ON:

- ✓ Practice formation, management and operations
- ✓ Review and negotiation of managed care contracts
- ✓ Corporate transactions including mergers and acquisitions and joint ventures
- ✓ Licensing, peer review and disciplinary matters
- ✓ Professional liability and risk management
- ✓ Governmental and payor inquiries and investigations
- ✓ Medical staff relations and credentialing
- ✓ Employee relations and benefits

For assistance or information contact
Lisa D. Taylor, Esq.
James J. Shrager, Esq.


HANNOCH WEISMAN

A Professional Corporation, Counsellors at Law
4 Becker Farm Road, Roseland NJ 07068
973-535-5300

Mercer County history: 150 years

Last month, the Mercer County Medical Society (MCMS) celebrated its 150th anniversary and honored William E. Ryan, MD, with his induction in the MCMS Hall of Fame. Ryan is a well-known Mercer County physician, community leader, past-president of MCMS, and 200th president of the Medical Society of New Jersey.

In 1848, a handful of dedicated Mercer County physicians planned to establish a medical society in their district. Ten years earlier, Mercer County was carved out from parts of neighboring Hunterdon, Middlesex, Burlington, and Somerset Counties. On May 23, 1848, seven charter members held the first meeting of the Mercer County District Medical Society at Samuel Kay's Tavern on Warren Street in Trenton. By the year 1890, membership increased to 48, and three sections were formed: medicine, surgery, and gynecology, representing the budding specialties.

From its inception, MCMS played an active role in serving the medical and health needs of the community while safeguarding the standards of the profession. In a

large brown leather notebook, the minutes of the MCMS meetings from May 1, 1883, through December 31, 1904, were faithfully recorded and preserved. These minutes give the present-day historian a window through which the evolution of organized medicine in Mercer County may be glimpsed.

Like today, the founding fathers and successive generations were concerned about patients, the state of health in the community, ethical standards, continuing medical education, new clinical knowledge, and technical innovations, but also enlightened legislation for the protection of the citizens and the profession. Some of the early members of MCMS were political and legislative leaders in the community, including, John Woolverton, MD, who served as MCMS president in 1853, state senator in 1868, and then mayor of Trenton, and Henry B. Costill, MD, who served as director of the New Jersey state Department of Health for three years and became president of MCMS in 1895.

At early MCMS meetings, interesting cases and epidemics were discussed, a speaker or essayist presented a talk on a subject of novelty, professional conflicts were resolved,

and complaints were heard and investigated.

In recent years, MCMS continued to broaden its community involvement. Ariel Abud, MD, and Frank Pizzi, MD, both past-presidents, started a Community Action Committee charged with means and ways to inform the community and protect patients in the face of the turbulence resulting in the health care delivery system in the aftermath of the health care reform debacle. The late J. Donald Ginhardt, MD, a MCMS past-president, established the Political Breakfast, a forum for members of MCMS to meet with politicians and legislators.

Health screening programs and community medical education programs sponsored by MCMS are regularly held in *The Times* Community Room. The office of MCMS and Executive Director Linda L. McGhee continue to be resources for the community.

MCMS now is looking ahead, to a future of a health care system where access, quality, and cost are held in optimum balance.

Ismail Kazem, MD, is a member of the MSNJ Council on Communications and serves as editor for the Bulletin of the Mercer County Medical Society.

Lowest Premiums for Quality Malpractice Insurance

The Joseph A. Britton Agency can help make it happen. If you are a preferred risk¹, you can qualify for preferred rates². We are also the best source for IPA, PHO, and Healthcare network discounts. Compare these annual premiums at occurrence limits of \$1,000,000/\$3,000,000:

• Internists	\$ 5,331	• General Surgeons	\$18,453	• Neurosurgeons	\$43,448
• Ob-Gyns	\$39,000	• Urologists	\$11,993	• Psychiatrists w/ect	\$ 2,937
• Radiologists	\$ 5,331	• Plastic Surgeons	\$23,350	• Anesthesiologists	\$ 8,572

With 30 years experience, the Britton Agency has proven exceptional in packaging malpractice insurance. Our professional staff and size assure you the benefits of specialized, personal service while offering you quality insurance at the lowest cost.

Call today for a free consultation - Start saving tomorrow



Joseph A. Britton Agency, Inc.

Healthcare & Professional Liability Insurance
855 Mountain Avenue, Mountainside, NJ 07092

(908)654-6464 • Fax: (908)654-1422 • 1(800)462-3401

¹Underwriting approval required. ²May need groups of 3 or more depending on specialty.



Druker, Rahl & Fein

Business Consultants
Certified Public Accountants

We have your prescription to profitability

We're Druker, Rahl and Fein, the accountants and advisors
to physicians and health care providers.

...Managed Care..Government Regulations

..the industry is changing..quickly.

How will these changes affect your practice?

You have questions and you need answers.

Our medical services experts will assist you
in developing a strategy to
succeed in this dynamic environment.

Leaders in:

Cost Accounting • Strategic Planning • Group Practice Formation • Tax
Managed Care Analysis • Practice Valuations • Practice Management

200 Canal Pointe Boulevard • Princeton, NJ 08540-5998 • 609-243-9700 • FAX 609-243-9799

Contact Robert J. Rahl, CPA

People

WILLIAM N. HAIT, MD, PhD, IS AN OUTSTANDING TEACHER, RESEARCHER, AND ADMINISTRATOR. HAIT ALSO TREATS PATIENTS AT THE CANCER INSTITUTE OF NEW JERSEY (CINJ), A CENTER HE HAS GUIDED SINCE ITS FOUNDING IN 1993.

UNDER HAIT'S LEADERSHIP, CINJ OBTAINED THE PRESTIGIOUS NATIONAL CANCER INSTITUTE (NCI) CANCER CENTER DESIGNATION, THE ONLY ONE IN NEW JERSEY. HAIT IS PRESIDENT OF THE AMERICAN CANCER SOCIETY, MIDDLESEX DIVISION, AND SERVES ON VARIOUS COMMITTEES WITH THE AMERICAN FEDERATION FOR MEDICAL RESEARCH, THE AMERICAN ASSOCIATION FOR CANCER RESEARCH, THE AMERICAN SOCIETY OF CLINICAL ONCOLOGY, AND THE AMERICAN ASSOCIATION OF CANCER INSTITUTES. HAIT IS FOUNDING EDITOR OF *CANCER THERAPEUTICS* AND ASSOCIATE EDITOR OF *ONCOLOGY RESEARCH*.



Dr. William Hait

Q. Were you prepared for the challenges you faced with the Cancer Institute of New Jersey (CINJ)?

A. I was head of medical oncology at Yale Medical School and associate director of the Yale Cancer Center for Clinical Sciences. I had much experience

in oncology and in how cancer centers are structured and how they function. I arrived at CINJ in 1993. Before 1993, there was much planning that had taken place, led by UMDNJ-Robert Wood Johnson Medical School, Robert Wood Johnson University Hospital, and St. Peter's University Hospital. Dr. Michael

(continued on page 29)

of the Year

Bill Berlin, PhD

GOVERNOR CHRISTINE TODD WHITMAN CONTINUES TO BE AN ADVOCATE FOR A PROGRESSIVE, PATIENT-ORIENTED APPROACH TO IMPROVING THE HEALTH AND OVERALL QUALITY OF LIFE OF NEW JERSEYANS. IN ALL AREAS OF HEALTH POLICY, GOVERNOR WHITMAN HAS SOUGHT THE ACTIVE PARTICIPATION AND ADVICE OF HEALTH CARE PROFESSIONALS, PATIENTS, AND BUSINESS AND LABOR LEADERS. A SAMPLING OF HER ACCOMPLISHMENTS INCLUDES THE 40-CENT TOBACCO TAX, FUNDING FOR CHARITY CARE, THE HOSPITAL RELIEF FUND, ADVOCACY FOR WOMEN'S REPRODUCTIVE RIGHTS, SIGNING OF THE HEALTH CARE QUALITY ACT, COMMITMENT TO MINORITY HEALTH ISSUES AND SENIOR CITIZEN SERVICES, INITIATING A NEW JERSEY VERSION OF THE CHILDREN'S HEALTH INSURANCE PROGRAM, MEDICAID MANAGED CARE, AND WELFARE REFORM FOR THE GARDEN STATE.

Q. What do you consider to be your major achievement in the area of health care?

A. I consider the successful effort to establish a more stable funding source for the New Jersey Charity Care Program to be a major achievement of my administration. MSNJ played a key role

in making this happen. I also feel that the ongoing development of the New Jersey KidCare Program, to provide coverage for children who are uninsured, will be a hallmark of my tenure in office.

Q. One of your major achievements has been enactment of the Health Care Quality

(continued on page 28)



Governor Christie Whitman

In the Spotlight

(continued from page 27)

Act. But there is some concern about how that Act will be monitored, along with its impact on costs. Do you share these concerns?

A. Because the Department of Health and Senior Services has embarked on an inclusive stakeholder process that will produce comprehensive regulations to effectively implement the Health Care Quality Act, I believe we will have in place the appropriate level of monitoring and rules that consider costs.

Q. Some people also have given you high marks for your staunch defense of women's reproductive rights. Do you see this as a health care issue?

A. I believe women's reproductive rights are an important health care issue. I have said many times that these issues are best decided by women in consultation with their physicians. I feel strongly that the doctor/patient relationship must be preserved in this area of health care.

Q. New Jersey still is undergoing the transition to managed care. Are there any other ways in which you see government playing a role in facilitating this transition?

A. New Jersey has been a leader in protecting consumers and health care providers as we continue to transition to a managed care environment. Through our HMO rules, the Health Care Quality Act, and our prompt pay regulations, we have been on the cutting edge of effective advocacy for responsible HMO management. I believe our state has acted appropriately by requiring coverage of certain services, by issuing HMO report cards, and by instituting an independent appeals process for medical decisions. Although I anticipate additional efforts to protect consumers and providers, I hope we give these innovative programs and policies a chance to work so that we can strike the proper balance between protection and cost management.

Q. What do you see as the other major trends and issues in health care?

A. I believe that government must continue to find ways to assist those who are uninsured and underinsured. Providing affordable health care will continue to be a major issue well into the next century. I also am closely monitoring our efforts to recoup monies from the tobacco companies. If we are successful in

securing a judgment or settlement we must make sure that the dollars we receive are spent on important public health considerations.

Q. There are an estimated million uninsured people in New Jersey. New Jersey KidCare should help, but is there anything else we should be doing in this area?

A. First and foremost, we must look for ways to provide affordable health insurance to those employers and individuals who wish to purchase it. That is why it is important to strike the proper balance between managed care and the needs of patients and providers. I am committed to expanding New Jersey KidCare, as quickly as we can, to make sure that our children receive the kind of quality care they deserve.

Q. What are your health care priorities for the year ahead?

A. I am proud of our efforts to reform the certificate of need process and it is a priority to see this process through to a successful conclusion. I also anticipate innovative charity care/managed care demonstration program, and am hopeful that we will realize benefits from our efforts to secure tobacco judgment or settlement.

(continued from page 26)

Clo was the interim director and major force who worked on the planning efforts for the CINJ. I had to take a strategic plan and convert it into reality, which required recruiting and much organizing.

Q. What was the biggest challenge you faced?

A. The biggest challenge was building a center from scratch because New Jersey didn't have a cancer center that was structured according to the regulations of the National Cancer Institute (NCI). New Jersey had very fine practitioners of oncology, good hospitals, and coordinated oncology services, but it didn't have what most other states had: a center that was research based and provides cutting edge patient care. The challenge was to go from nothing to an organized cancer center that could go to NCI and apply for a major grant, which is very difficult to get.

Q. Why was this grant from NCI so important?

A. This grant gives you recognition by your colleagues around the country and around the world that you have a center of outstanding quality. Once you get the imprimatur from NCI, you have NCI designation and that allows many things to fall into place: credibility from colleagues, the ability to have a comfort level

for referring physicians that they no longer have to send patients to Philadelphia or New York City, that they have a designated NCI center conveniently located in New Jersey and they can send patients here.

Q. Have you been able to establish CINJ as a viable alternative to New York City and Philadelphia?

A. I think those physicians who know about us have used CINJ as a very viable alternative for patient care. CINJ is smaller and easier to deal with, and we are much more convenient to travel to and from. We went from 0 patients to over 25,000 patients this year, a tremendous growth for CINJ, and many of those patients would have gone to New York City or Philadelphia.

CINJ still is very new. Oncologists are aware of us but many primary care doctors and residents still need to find out about CINJ.

Q. How does CINJ compare to other academic centers, some of which are facing difficult financial problems?

A. CINJ is facing many of the same challenges as academic institutions. CINJ is a unit of the Robert Wood Johnson University Medical School, and, as such, it is part of the larger state university system—UMDNJ. CINJ is supported by several entities and we draw upon many of these resources in terms of our needs and pro-


grams. CINJ has a very large base of support—financial and intellectual. Also, we are not a hospital and do not have beds, and, therefore, we are not troubled by all those issues that are the most vexing for academic health centers.

Q. What are CINJ's major challenges?

A. The major challenge is to cure cancer, and we are determined to do it. In addition to seeing some of the cancers toppled, our major challenge will be to manage our growth. One of the great challenges will be to expand the center and at the same time to maintain the extraordinary quality, which is the key to it all.

Q. Where do you see the greatest progress in cancer research and treatment?

A. Over the last ten years, cancer research has identified why cells become cancer cells. Now we know the precise molecular changes that occur; we have brand new targets for therapies. These new therapies are highly specific for cancer cells that will change the face of cancer treatment in the next few years. I believe bladder cancer will be the first cancer to fall by the wayside because of curative treatment. And, we are doing some of that research work right here. I am also optimistic that the death rate from breast cancer will fall precipitously.



Wouldn't **you** rather

practice medicine

than **wrestle**

alligators?

Whatever challenges you face or opportunities you contemplate, the right legal counsel can spell the difference between a tangle of complications and a successful outcome.

Tamborlane & Printz focuses decades of experience and insight on your needs regarding managed care contracts, state and federal

**We
thought
so.**

compliance requirements, and countless other issues.

Call us and speak with attorneys called upon for guidance by America's most prestigious medical associations and health publications. We'll help you maximize the rewards and minimize the risks associated with providing quality health care.



Tamborlane & Printz, P.C.

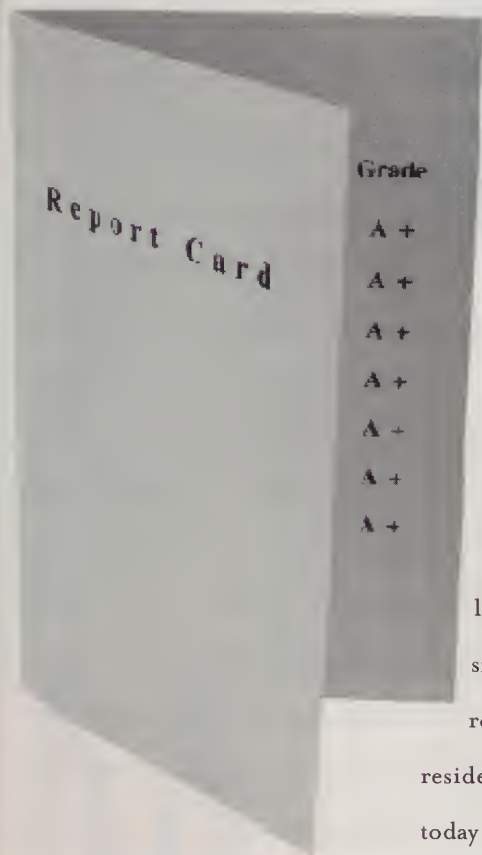
Counselors at Law

New Jersey: 908-789-7977 1044 Route 22 West, Mountainside, NJ 07092

Florida: 305-296-2700 1800 Atlantic Boulevard, Suite 208A, Key West, FL 33040

Email: law@tamborlane.com

IN PURSUIT OF INFORMATION: QUALITY CARE



MANAGED CARE PLANS HAVE GROWN EXPLOSIVELY IN RECENT YEARS.

OF ALL NEW JERSEY RESIDENTS WHO HAVE HEALTH INSURANCE, ONE-THIRD ARE IN MANAGED CARE PLANS. NOW, MORE THAN EVER, WE NEED OBJECTIVE WAYS TO MEASURE THE QUALITY OF HEALTH CARE. AND, THIS IS AN ACHIEVABLE GOAL.

Flora Davis

Early HMOs, have grown explosively in recent years. In 1993, roughly one million New Jersey residents were enrolled in HMOs; today that number is about 2.4 million. Of all state residents who have some form of health insurance, one-third are in managed care plans.

In this time of rapid change, there's a great need for objective ways to measure the quality of health care. Commissioner Fishman suggests that the best way to protect consumers and

improve care is to provide businesses and their employees with timely, accurate, and meaningful information on quality, so that they can compare health plans and providers and make informed choices. Providers, hospitals, and plans also need information on the quality of the care they provide if they're to improve it. What efforts should be made to improve the quality of health care?

Too few payers make quality a priority. In choosing health plans, business-

We're living through a time of revolutionary change in our health care delivery system," according to Len Fishman, New Jersey commissioner of the Department of Health and Senior Services. Managed care plans, particu-

es primarily consider the cost, the size of the plan's network of providers, which hospitals are included, and whether claims are processed promptly. Too often, the information available about quality is not timely. Facts gathered in 1996 are of limited interest by 1998. And, there is very little information on medical outcomes. The focus generally has been on process, yet the way to improve health care is by studying outcomes—the consequences of the process of treatment. It's easier and less expensive to gather information on process, while it's often difficult even to define outcomes.

Assessments of quality often are based on claims data. Gathered for billing purposes, this information doesn't reveal much about what happened between provider and patient. However, claims materials are easier to acquire than patient medical records. Other concerns center around whether hospital DRG data should be used to assess quality.



Bryan Markowitz, assistant vice-president, Health Affairs, New Jersey Business and Industry Association, comments on the ability of others to judge quality.

Sometimes in trying to find ways to judge quality, experts may measure the wrong things. Bryan Markowitz, assistant vice-president of Health Affairs for the New Jersey Business and Industry Association, says that it's commonly assumed that the best hospitals have the lowest rates of cesarean section. However, no one knows whether a very low rate leads to more problems in infants.

Health care data seldom reflect the whole continuum of treatment. The continuity of care is difficult to trace. For instance, a hospital may wonder if it is doing too few or too many cesareans, resulting in a

potentially greater risk to the mother or the baby. To find out, the hospital needs to be able to track infants for months or years after birth. In addition, patient confidentiality generally has been an obstacle to tracing health care after release from a hospital. Would it be possible to collect data and maintain privacy by substituting codes for names?

Collecting accurate, meaningful information about quality in health care is difficult and expensive. To produce better data, doctors and hospitals will have to fill out extra forms unless a computerized system is developed. Alfred Tallia, MD, associate professor at UMDNJ-Robert Wood Johnson Medical School, notes that in his practice he already deals with 14 different health plans, each with its own unique requirements.

Where information on quality exists, consumers don't have easy access to it. David L. Knowlton, vice-president of the MIIX HealthCare Group, says that the payers have information but do not make it available to their employees.

Consumers can't seem get the information they need about physicians. Selecting a doctor is the only choice patients are permitted to make in managed care. Only 25 percent of all New Jerseyans who have employer-sponsored health insurance have a choice of three or more plans; about 50 percent of New Jerseyans are offered only one health plan. Participants disagreed about how forthcoming the plans are when consumers call with questions. The Medical Society of New Jersey (MSNJ) also has data on its physician members in the Physician Finder section on its web site www.msnj.org.

Malpractice statistics and data on mortality rates can be misleading. "The public doesn't understand how insurance companies work in this area," says Donna Pizzulli, vice-president of the New Jersey Hospital Association Information Services.



Donna Pizzulli of the New Jersey Hospital Association is concerned about public understanding of hospital records.

Patients need to know if there's an egregious pattern of lawsuits against a doctor or hospital, but beyond that, the simple fact that a physician has been sued may not mean very much, says Paul Weber, MSNJ director of Finance and Admini-

DHSS Commissioner Len Fishman was instrumental in the creation of the Report Card on HMOs.



stration. Similarly, if a doctor's (or hospital's) mortality rates are made public, the rates must be risk-adjusted so that providers who treat high-risk patients aren't made to look incompetent.

Consumers don't know how to judge quality. Consumer education is essential but may not be easy. Many of the issues involved in assessing quality are complex. Lou Marturana, managing director of the Health Care Quality Institute, notes, "People demand information in ten-second sound bites." Would consumers use data on quality if the information was readily available? It appears consumers prefer to get physician referrals from acquaintances and expect the selected physicians to determine the appropriate hospitals for treatment. However, there is some evidence that quality information is used by consumers when it is available.

The question then becomes, what can be done? Recommendations for action are easy to categorize.

1. Get all the stakeholders together to discuss health care quality issues.

Ensuring Quality Care

The state of New Jersey, provider organizations, and independent nonprofits have taken steps to measure and improve health care quality.

1. Report Card on HMOs. "New Jersey HMOs: Performance Report" from DHHS presents a comparison of 12 HMOs in the state.

2. Report Card on Coronary Bypasses. "Coronary Artery Bypass Graft Surgery in New Jersey, 1994-1995" by DHHS, compares mortality rates among the 13 New Jersey hospitals approved to do coronary artery bypass graft (CABG) surgery.

3. New Jersey Care 2000. From the Department of Human Services, Division of Medical Assistance and Health Services, this program is moving all Medicaid recipients into managed care; about 90 percent of TANF families now are enrolled in 11 HMOs.

4. KidCare. This initiative, designed to provide comprehensive health insurance for uninsured children, is enrolling youngsters under the age of 19 whose families have incomes at or below 200 percent of the federal poverty level. There are about 100,000 low-income uninsured children in New Jersey.

5. ORYX. JCAHO is integrating performance measures into the accreditation process, and will require hospitals, long-term care facilities, and health care networks (such as HMOs) to collect performance data.

6. ORYX PLUS. This voluntary program was designed for hospitals that want to participate in a national database, which will make it possible to compare performance on similar types of medical service.

7. AMAP. The voluntary self-assessment will accredit physicians in five areas: credentials, qualifications, environment of care, clinical

performance, and clinical outcomes. MSNJ is the first state medical society to participate in AMAP.

8. New Jersey Care 2000. The Peer Review Organization of New Jersey is measuring the quality of the care HMOs provide to Medicaid beneficiaries.

9. HCQIP. The PRO's Health Care Quality Improvement Program (HCQIP) was designed to benefit Medicare beneficiaries. Working with providers, HCQIP mounts projects related to specific health problems.

10. Hospital Performance Review for Specialty Treatments. This project by the Health Care Quality Institute is using DRG data from all New Jersey hospitals to review how well each institution performs in its treatment of specific disorders. The focus is on septicemia, heart attacks, pediatric asthma, bronchitis, pneumonia, hip and knee replacements, and C-sections.

11. Inappropriate Use of Antibiotics. In a pilot project, the Health Care Quality Institute, with support from CDC, is matching a health plan's office visit claims data to its pharmacy database. The goal is to find out how often a patient diagnosed with a cold or some other disorder for which antibiotics are not helpful, is given a prescription for the drugs.

12. Provider and Physician Assessment. This pilot project by the Health Care Quality Institute brought registered nurses together to explore the question: What can nurses tell us about the quality of hospitals and of doctors?

2. Establish a uniform medical record.

3. Provide consumers with more information about physicians.

4. Educate consumers and purchasers about health care quality.

5. Hold more focus groups with consumers and purchasers to determine the information they want to judge quality.

6. Contact companies that do consulting on benefits and learn from their studies and their methodologies.

7. Try to ensure that the American Medical Accreditation Program (AMAP) is responsive to the needs of consumers.

8. Explore quality measurement systems in use elsewhere in the country.

Is quality health care an elusive concept or an achievable goal? It seems that it is both. Quality is hard to define and different people undoubtedly conceive of it differently. The sick and the well, the rich and the poor, payers and providers, all have different priorities. Nevertheless, health care quality is an achievable goal. Though there's a long way to go, New Jersey's stakeholders are making a strong start. ■

Our doctors aren't just great. They're the best.



Hudson County's best doctors practice at St. Mary Hospital of Hoboken and St. Francis Hospital of Jersey City. With nearly 600 skilled, caring professionals, our medical staff includes a growing number of leading specialists who are nationally-recognized experts in fields like perinatology, internal medicine and psychiatry.

So when you're looking for a doctor, choose the best.SM
Call (201) 418-2020.

**ST. FRANCIS
HOSPITAL**
of Jersey City

**ST. MARY
HOSPITAL**
of Hoboken

The best doctors and nurses. Right in your neighborhood.SM

You didn't build your reputation just so your insurance company could destroy it.

How your insurance provider handles malpractice suits can have a critical impact on your future. Many insurance companies will make little effort to defend you against lawsuits, preferring instead to settle. In those cases, the claim becomes part of your resume forever, and may affect your future. As you know, it's common practice for managed care organizations to deny participation due to past malpractice claims, including out-of-court settlements.

Consider instead the comprehensive services of B.C. Szerlip. We offer 60 years of experience providing top-quality insurance services to physicians and surgeons. We represent only "A" rated insurance companies who provide superior legal defense. Almost 70% of lawsuits against our customers are dropped. Our expert legal defense team wins more than 80% of the remaining cases. So there's almost never a loss or settlement to put a dent in your hard-earned reputation.

Due to the loyalty of our customers, B.C. Szerlip has achieved unparalleled financial stability. No matter when a claim is filed, we'll be here to defend you.

To give you a taste of our full-service approach, we'd like to send you a fascinating booklet, *The Managed Care Survival Kit for Physicians*. To receive your own obligation-free copy, please call us at 800-684-0876.

BCSZERLIP INSURANCE AGENCY INC.

99 WOOD AVENUE SOUTH, PO BOX 217
ISELIN, NJ 08830-0217
800-684-0876 • 732-205-9800
FAX: 732-205-9496
E-MAIL: bcszerlip@aol.com

*Professional Insurance Services
for Health Care Providers*

John Paul Dizzia, P.C. ATTORNEYS AT LAW

Legal Counseling and Representation to Medical Professionals in administrative, regulatory and disciplinary matters before the State Board of Medical Examiners, the Department of Insurance, the Division of Medical Assistance and Health Services, and in the law relating to professional rights, responsibilities, ethics and practice issues.

Member:

- National Health Lawyers Association
- Health and Hospital Law Section,
New Jersey Bar Association
- New Jersey Association of
Professional Mediators

108 North Union Ave.
P.O. Box 886
Cranford, N.J. 07016

Call: (908) 276-6111
FAX: (908) 276-5833
E-mail: JPDLEGAL@AOL.COM

ImageFIRST™

MEDICAL WEAR

- Lab Coats
- Dental Jackets
- Patient Gowns • Towels
- Sheets • Pillow Cases
- And More

**For Information Call
1-800-408-0370**

**ONE WEEK FREE
SERVICE WITH MENTION
OF THIS AD!**

FIGHTING FOOD- BORNE ILLNESSES

Robin K. Levinson

The vast majority of food-borne illnesses are self-limiting bouts of gastrointestinal distress; victims rarely consult a health care professional. But when diarrhea becomes bloody or vomiting continues for several days, or a patient feels sick enough to seek medical attention, prompt treatment may prevent serious complications, or at least make patients more comfortable until the episode passes.

Food-borne infections are so common in the United States that it is pru-

dent for doctors to consider these diagnoses in any patient presenting with severe diarrhea, vomiting, and abdominal pain—with or without fever, food-safety experts say. According to rough estimates by the federal government, food-borne diseases strike 6.5 million to 81 million people and kill 9,100 people each year in the United States. But the precise incidence is unknown since food-borne diseases, such as salmonellosis and campylobacteriosis, are notoriously under-reported. Each year in New Jersey, the Department of Health

FOOD-BORNE INFECTIONS ARE SO COMMON THAT IT IS PRUDENT FOR A PHYSICIAN TO CONSIDER THIS DIAGNOSIS IN ANY PATIENT PRESENTING WITH SEVERE DIARRHEA, VOMITING, AND ABDOMINAL PAIN. FOOD-BORNE DISEASES KILL 9,100 PEOPLE EACH YEAR IN THE UNITED STATES. THE NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES RECEIVES AN AVERAGE OF 3,456 REPORTS OF COMMUNICABLE DISEASES. BUT STEPS CAN BE TAKEN TO PREVENT OUTBREAKS AND TO TREAT PATIENTS.

and Senior Services receives an average of 3,456 reports of 11 communicable diseases that were probably food-borne. In addition to salmonellosis and campylobacteriosis, these reportable diseases include botulism, cryptosporidiosis, *E. coli* O157:H7 infection, giardiasis, hepatitis A, listeriosis, shigellosis, trichinosis, *Vibrio* (other than cholera) infection, and yersiniosis. John H. Brook, MD, MPH, acting state epidemiologist, says the number of reported cases most likely represents "a small ice chip out of the tip of the iceberg."

It is tempting but usually futile to blame the patient's last meal, Brook says. Many food-borne pathogens incubate 6 to 72 hours or longer before producing symptoms; *Campylobacter jejuni* incubates 2 to 11 days later.

While anyone can fall victim to a food-borne disease, about 20 percent of the population is considered to be at high risk for these illnesses and their complications. High-risk groups include the very young, the very old, the immunocompromised, pregnant women, cancer patients, the malnourished, people with liver disease (particularly alcohol-related), transplant recipients, gastric surgery patients, achlorhydria patients, and long-time steroid users. Regular users of antacids are at elevated risk because stomach acid may not be strong enough to kill ingested pathogens. Patients on antibiotics are at high risk and remain that way until their intestinal flora return to normal levels—about two weeks after finishing a prescription, according to researcher David W. Acheson, MD, director of the Food Safety Initiative at the New

England Medical Center in Boston. By competing with pathogens for space and resources, these normal flora prevent disease-causing microorganisms from colonizing and invading the intestinal lining, he explains.

Acheson suggests that doctors advise their high-risk patients to strictly follow safe food-handling guidelines. A concise list of guidelines is available on the world wide web (<http://www.fightbac.org/steps/index.html>). High-risk patients also should be encouraged to avoid eating risky foods, such as unpasteurized juice, raw or rare hamburger, and raw shellfish, especially from southern waters. Oysters, clams, and mussels are vulnerable to contamination with *Vibrio vulnificus* and other *Vibrio* species, naturally occurring marine bacteria that, if ingested, can kill someone with symptomatic or

**A STANDARD BATTERY OF
STOOL TESTS IS NOT
CRUCIAL BUT MAY HELP
THE PHYSICIAN PRESCRIBE
THE MOST APPROPRIATE
ANTIBIOTIC.**

asymptomatic liver disease in a matter of days or even hours. *E. coli* O157:H7 can survive and amplify in a variety of foods, including unpasteurized fruit juice. Undercooked ground beef tainted with *E. coli* O157:H7 was the culprit in the infamous Jack in the Box food-poisoning outbreak of 1992, in which more than 700 people were sickened and four children died. Although the federal government now prohibits the sale of ground beef that tests positive for *E. coli* O157:H7, only a tiny fraction of the ground beef sold in this country is tested, and no amount of testing guarantees safety. Thorough cooking destroys *E. coli* and other food-borne bacteria.

While food-borne gastroenteritis usually resolves itself, antibiotics may be indicated if symptoms continue more than a few days or if the patient is immunocompromised. Antibiotics may prevent the pathogen from invading the bloodstream, where it can lead to bacteremia and septic shock. Another rare complication of *Salmonella*, *Campylobacter*, *Shigella*, and *Yersinia* infections is reactive arthritis, which may develop three weeks to two months after acute symptoms dissi-

pate. In people with a certain genetic predisposition, salmonellosis can lead to Reiter's syndrome. Though exceedingly rare, Guillain-Barré syndrome may result from infection with the most widespread food-borne pathogen, *Campylobacter jejuni*, commonly found in raw or undercooked chicken.

The most dangerous complication of *E. coli* O157:H7 infection is hemolytic uremic syndrome (HUS), which has become the leading cause of acute kidney failure in children. Of the estimated 20,000 Americans who get sick from *E. coli* O157:H7 each year, HUS complications kill approximately 500, most of them children, according to federal government statistics. There is no specific treatment for HUS. The patient is hospitalized and given supportive therapy, such as dialysis and antihypertension medication, if needed. Synsorb-Pk, an experimental treatment undergoing clinical trials in the United States and elsewhere, appears to mop up the toxins in the intestinal tract.

Ordering the standard battery of stool tests is not crucial but may help



E. coli O157:H7 adhering to ground beef.
© Jorge Girón and James Kaper, University of Maryland School of Medicine.

the physician prescribe the most appropriate antibiotic. A stool test also can rule out *E. coli* O157:H7 infection, which actually may be worsened by antibiotic treatment. When exposed to antibiotics in test tubes, *E. coli* O157:H7 releases Shiga toxins as they die and fall apart. A similar scenario might occur inside the human body, explains Acheson, whose team is working on a Shiga toxin vaccine. He adds that certain antibiotics may stress the bacteria into increasing its toxin output by turning on its Shiga toxin genes. There are at least two assays—Premier EHEC and Premier *E. coli* O157:H7—that can detect the bacteria and its toxins, respectively, in stool specimens.

Brook acknowledges that managed care pressures may dissuade physicians from ordering a full range of stool tests. Yet, when a test confirms a reportable food-borne infection, the doctor legally is obligated to

notify the local health department. As the eyes and ears of public health officers, Brook says physicians are in a unique position to flag public health problems. "I'm trying to get physicians to think epidemiologically," he says. "When a patient comes in with an apparent food-borne illness, the doctor should try to identify the origin of the illness, such as a restaurant, social function, or home. Another question to ask is whether the patient knows of anyone else with whom he or she dined who also has gotten sick."

If a possible outbreak is suspected, the physician should telephone the local health officer, who may have knowledge of similar illnesses stemming from the same eatery. Brook notes that reporting these cases to the local health office should not take more than a minute or two.

Sometimes an investigation triggered by a doctor's report identifies an outbreak or alerts health officials to hazardous food-handling practices in a particular eating establishment, nursing home, or day care center. Steps then can be taken to prevent future outbreaks. Brook says he encourages health officials to provide feedback so the physician doesn't think the information provided "fell into a black hole."



HEALTH LAW PRACTICE

*representing healthcare providers,
including physicians, physician groups, other
clinical professionals, academic medical
centers, multihospital systems, independent
acute care and specialty care hospitals,
ambulatory care centers, and nursing and
assisted living facilities*

For more information or a copy of our
New Jersey Health Law Advisory,
please contact
Alma L. Saravia
51 Haddonfield Road
Cherry Hill, NJ 08002 • (609) 488-7300

DUANE, MORRIS & HECKSCHER LLP
A PENNSYLVANIA LIMITED LIABILITY PARTNERSHIP

Cherry Hill and Newark, New Jersey
with additional offices in
Pennsylvania • New York • Washington, D.C.
Delaware • Florida

THE RIGHT PRESCRIPTION FOR YOUR CALLERS



Message-On-Hold Systems

Use your telephone music-on-hold feature to:

- ✓ Promote Services
- ✓ Reassure Callers
- ✓ Educate & Inform
- ✓ Encourage Referrals



ORDER ONLINE

PATIENTS ON HOLD LIBRARIES

complete package for **Only \$495**
go to www.holdcom.com/libraries

HOLDCOM

Serving the NJ Healthcare Industry Since 1987

Call 1-800-666-6465
www.holdcom.com



Money



Yours- Hard Earned

Why should an insurance company hold it for 90 days?

**Medi-Bill Associates is the ONLY full service medical billing
company that pays physicians on their assigned claims
WITHIN 72 HOURS!**

We do all the work: claim review, submission and follow-up.

Why get paid in 90 days, when you can get paid in 3?

Don't Just Bill. . . MEDI-BILL !



Medi-Bill Associates, Inc.

Advance Funding/Electronic Billing

Call 800-546-2414 for a FREE consultation!

NEW JERSEY HOSPITALS ACHIEVE MAGNET STATUS

ONLY 13 HOSPITALS IN THE UNITED STATES HAVE ACHIEVED THE MAGNET STATUS DESIGNATION FROM THE AMERICAN NURSES CREDENTIALING CENTER (ANCC) FOR EXCELLENCE IN NURSING SERVICE AND PATIENT CARE OUTCOMES, AND NEW JERSEY HAS SIX OF THOSE RECIPIENTS. THE NEW JERSEY MAGNET STATUS HOSPITALS ARE: HACKENSACK UNIVERSITY MEDICAL CENTER; ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL; JERSEY SHORE MEDICAL CENTER; ST. PETER'S UNIVERSITY HOSPITAL; THE MEDICAL CENTER OF OCEAN COUNTY; AND RIVERVIEW MEDICAL CENTER.

Mequerite K. Schlag, RN, MSN, EdD

In today's health care environment, attention is focused on an institution's ability to ensure quality patient outcomes and to provide a professional practice environment for staff during a time of diminishing resources. Currently,

there are several mechanisms available to assess institutional performance, such as reviews by state and federal regulatory agencies and the Joint Commission on Accreditation of Healthcare Organizations, and benchmarking at the local, state, and

national levels. None of these traditional mechanisms focus specifically on the collective work of nurses at a particular institution.

The American Nurses Credentialing Center (ANCC) Magnet Nursing Services Recognition Program was



purposely designed to evaluate the level of excellence in nursing services and nursing care at the institutional level. Jennifer Matthews, PhD, RN, CS, director of Accreditation and Magnet Recognition Programs, observes, "Magnet hospitals have a professional practice environment where physicians and nurses work collaboratively to ensure quality patient outcomes."

A NCC initiated the Magnet Recognition Program for Excellence in Nursing Services in 1994 as the highest level of recognition available to institutions that provide short-term, acute care services. The program recognizes excellence in nursing service management philosophy and practices; adherence to standards for improving quality of care; leadership of the senior-level administration in supporting professional nursing practice; competence of nursing personnel; and attention to the cultural and ethnic needs of patients and care providers. The objectives of the Magnet

Recognition Program are to recognize and build programs of excellence in the delivery of nursing care to patients; to promote quality within an environment that supports professional nursing practice; to provide a vehicle for sharing successful nursing practices and strategies among institutions; and to promote positive patient outcomes.

When describing the program, Richard Hader, RN, PhD, associate executive director and chief nurse executive, Jersey Shore Medical

Center, comments, "The most exciting component of the Magnet Recognition Program is that the process recognizes the professional commitment to nursing excellence at all three of the Meridian Health Care System acute care facilities. It inspires a team commitment of excellence not only by the nursing staff but by the entire hospital community." In 1999, ANCC will expand the Magnet Recognition Program to include long-term care institutions.

Magnet Designated Hospitals

- Baptist Hospital of Miami—Miami, FL
- Hackensack University Medical Center—Hackensack, NJ
- Inova Fairfax Hospital—Fairfax, VA
- Jersey Shore Medical Center—Neptune, NJ
- Mayo-Rochester Hospital—Rochester, MN
- The Medical Center of Ocean County—Point Pleasant, NJ
- The Miriam Hospital—Providence, RI
- Riverview Medical Center—Red Bank, NJ
- Robert Wood Johnson University Hospital—New Brunswick, NJ
- St. Joseph's Hospital of Atlanta—Atlanta, GA
- St. Peter's University Hospital—New Brunswick, NJ
- University of California, Davis Medical Center—Sacramento, CA
- University of Washington Medical Center—Seattle, WA

In 1997, the American Hospital Association conducted a series of focus groups across the country. Throughout the interviews, the nurse was identified by the public as a key factor in the quality of their hospital care. Today's informed consumer seeks out hospitals where there is quality nursing care. "Magnet status assures the public that we go beyond meeting the required standards and strive to achieve the highest standard possible," says Toni Fiore, RN, MA, vice-president of patient care and chief nursing officer, Hackensack University Medical Center.

ANCC magnet status can provide an institution with internal and external benefits. Internally, the nursing staff enjoys the recognition of external validation of their excellent clinical practice. It also demonstrates to staff that they are working in an environment where they are valued.

External benefits to an institution begin with the recognition of the institution's nursing excellence at the local, state, and national levels. "We have long believed that the pro-

THE PROCESS RECOGNIZES THE PROFESSIONAL COMMITMENT TO NURSING EXCELLENCE.

fessional registered nurses practicing at Robert Wood Johnson University Hospital are among the very best in the country. Magnet designation provides a mechanism to validate our belief about the high quality of nursing care we provide," states Mary Crabtree Tonges, RN, PhD, MBA, senior vice-president, Nursing and Patient Services, Robert Wood Johnson University Hospital.

An institution can promote its magnet status to the community

Marguerite K. Schlag, RN, MSN, EdD



through a variety of media. Promotional information about the award can be targeted to the community, physicians, other institutions, and to payers. In addition, the designation can assist in the recruitment of other highly qualified nursing staff, thereby further enhancing the institution's ability to provide quality patient care.

ACHIEVING MAGNET STATUS

Designation as a magnet hospital is based on a comprehensive evaluation process that uses the American Nurses Association's *Scope and Standards for Nurse Administrators*.¹ The institution applying for magnet status must provide documentation and evidence that supports the implementation of the ANA standards throughout nursing services. The application process begins with the decision by an institution to seek magnet status and progresses through three phases. Since the start of the program, 98 institutions have requested applications but only 13 institutions have successfully completed the entire application process.

Phase I consists of providing written responses and support materials

to demonstrate how the institution meets the ANA standards within the institution's organizational structure, management philosophy, and leadership. This is a time of intense work throughout the entire organization. The completed application is then sent to ANCC for review.

Phase II is the evaluation of the written document by the ANCC reviewers. First, the application is reviewed to determine if the core or baseline standards are met. Second, the document is assessed for the ability of the institution to meet the magnet status criteria. A minimum score must be achieved before a facility is considered for the third phase, a site visit evaluation.

The site visit is conducted by two professional registered nurses with extensive experience in nursing services administration, quality indicators, and nursing care within acute care environments. The purpose of the site visit is "to

verify, clarify, and amplify what is in the written application and evaluate the organizational milieu in which nursing is practiced."² The two- or three-day site visit agenda includes opportunities for the appraisers to have direct contact with the nursing staff, senior-level administrators, and physicians, and engage them in one-to-one discussion. The agenda also includes discussions with patients and community advocates.

Following the on-site visit, a written appraisal report is submitted to the ANCC Commission. After review of the written report and the supporting evidence, the Commission votes on the designation. There must be a majority affirmative vote to grant the magnet designation.

The designation is granted for a full four years.

Emphasis will continue to be focused on hospitals' ability to demonstrate the quality of care delivered. The Magnet Recognition Program is one way that hospitals can measure performance. This designation provides information to the public and recognizes the important contribution of nursing services to quality patient outcomes. ■

Dr. Schlag is administrative director, Center for Nursing Education & Research, Robert Wood Johnson University Hospital, in New Brunswick.

REFERENCES

1. American Nurses Association: *Scope and Standards for Nurse Administrators*. Washington, DC, American Nurses Association, 1996.
2. ANCC: *The Magnet Nursing Services Recognition Program for Excellence in Nursing Service: Instruction and Application Process*. Washington, DC, American Nurses Credentialing Center (ANCC), 1997.

Hackensack University Medical Center's Magnet Nurse champions are honored by ANCC.





Medical school never prepared you for this.

You studied and trained for years so you could help save lives. Yet the chances are far too high that you'll wind up in court someday, defending your decisions, your practice, and everything you believe in. Fortunately, you can do something now to help defend yourself. You can join the family of physicians, dentists and other healthcare professionals who make up the ProMutual and ProSelect companies.

Our Risk Management programs, renowned nationwide, can help you develop a safer office practice. Our Claim Services group works with you on a personal level when a claim is filed against you. And should your case ever reach the courtroom, you'll be well protected. We work with the finest defense counsel in the Northeast. And we win over 90% of the time.

For more than 20 years, the ProMutual and ProSelect companies have been devoted *exclusively* to serving the needs of healthcare professionals. We're not about to let you down now. Call 1-800-225-6168 for the name of an insurance agent near you, or visit our Web site at www.promutualgroup.com. And find out just how much liability protection your money can buy.

TALK TO THE PROS.



ProMutualGroup

ProMutual is a member of the ProMutual Group of companies, offering healthcare liability protection in Massachusetts. ProSelect is a member of the ProMutual Group of companies, offering healthcare liability protection in NJ, CT, MA, RI, VT, ME*, and NY*.

* Pending approval of the Division of Insurance in these states.

Rated "A-"
for Overall
Liability
Coverage by
A.M. Best.



"A lot of companies may settle because it can be cheaper than defending a case. But if a case is defensible, we will absolutely defend it through trial. This helps discourage frivolous suits and, most importantly, it protects our policyholders."



Susan A. Smith
Claim Representative

WHATEVER HAPPENED TO MENTAL HEALTH?

MANY ISSUES ARE RAISED BY THE MARRIAGE BETWEEN MANAGED CARE AND MENTAL HEALTH. IN MANAGED CARE'S ONGOING STRUGGLE TO CONTROL HEALTH CARE COSTS, COVERAGE FOR MENTAL HEALTH HAS BEEN THE BIGGEST CASUALTY. MOST PLANS HAVE CAPPED INPATIENT MENTAL HEALTH BENEFITS AND CRITICS ARGUE THAT THE FIGURE IS UNACCEPTABLY LOW.

Bill Berlin, PhD



Susan Bauman, MD, had a problem. The nervous teenager who sat across the desk from her had been losing weight rapidly. The girl described feeling anxious about swallowing, and her worried mother had brought her in, rightly concerned about an eating disorder.

Bauman, a primary care physician with The Delaware Valley Family Health Center and MSNJ member, had experience with anorexia nervosa, but this

teenager reported only some of its symptoms. The case seemed complicated, and Bauman advised the mother to see a specialist in eating disorders. Bauman knew a therapist she trusted, but the practitioner was not covered under the family's managed care plan.

The mother called the managed care company's 800 number and was given the name of three therapists. She chose one, who, in a few days called Bauman, presenting herself as an expert in eating

disorders. She recommended that the teenager be placed in a hospital with a feeding tube.

Bauman felt frustrated. She had questions about the recommended treatment, worrying that forced eating would only aggravate the teenager's problem. She knew nothing about the therapist's background or reputation. The girl's mother had questions, too, and wanted another referral, this time to someone who came with a personal, not bureaucratic, endorsement.

Thankfully, this story has a happy ending. Bauman's therapist of choice had applied for inclusion in the family's managed care plan and soon was accepted. The therapist came up with a very different treatment plan based upon outpatient psychotherapy. Over the next few months, the teenager gradually began to eat more, gain weight, and after a year, she was back to her self again.

This situation illustrates one of the many issues raised by the unhappy marriage between managed care and mental health. "My biggest problem with managed care," says Bauman, "is that the therapists I'm most familiar with are not in the system." Although the referral process with medical specialists is comparable, the limitations are more acute when it comes to mental health. The medical specialties generally involve fairly standardized treatments, whereas with mental health, therapeutic approaches may vary widely and the personal chemistry between provider and patient often is crucial. "Just because someone might be a clinical psychologist, a social work-

er, or even a psychiatrist," Bauman says, "doesn't mean that he or she has the expertise, style, or personality that fits my patient."

Bauman's frustration is echoed by other primary care practitioners. A 1997 survey of 5,000 primary care physicians by the Center for Studying Health System Change found that 68 percent of respondents said that they usually cannot obtain high-quality inpatient mental health care. Seventy-two percent reported that they often cannot find high-quality outpatient mental health services for their clients.

The concerns of primary care physicians pale beside the collective anger and resentment of mental health professionals. In managed care's ongoing struggle to control health care costs, coverage for mental health—often referred to as behavioral health—has been the

biggest casualty. Today, 78 percent of insured Americans are governed by a managed behavioral health arrangement, often administered by a separate "carve-out" company such as Merit Behavioral Care Corporation or Green Spring Health Services, while only 26 percent participate in HMOs for general health care. Most plans have capped inpatient mental health benefits at \$5,000, an amount that critics argue is unacceptably low. For those in medicine who foresee a nightmare scenario of bureaucratic, overly restricted services, mental health care may have arrived there first.

A 1998 report prepared by the Hay Group, a Washington, DC—consulting firm, for the National Association of Psychiatric Health Systems tracked the downward trend in behavioral health coverage and utilization:

1. The value of behavioral health care benefits fell 54 percent between 1988 and 1997, compared to a 7 percent decline in the value of general health care benefits.

2. Psychiatric office visits declined 8.9 percent from 1991 to 1996, compared to an increase in general office visits of 27.4 percent during the same period.

Susan Bauman, MD



3. Inpatient days per 1,000 people fell by 68.8 percent for behavioral health disorders compared to a decline of 18 percent for all other types of general health problems.

4. By 1997, the majority of the plans was imposing limits on inpatient psychiatric care and outpatient behavioral health care. The maximum limit on outpatient office visits in 1997 was usually 20, compared to 50 in 1988.

The impact on practitioners has been profound. Mental health professionals who work with managed care complain of 10 to 20 hours of paperwork per week, lengthy quarterly reports to justify continued treatment, and an alarming loss of patient confidentiality. "What is required in most managed care reports is incredible," says Larry Perfetti, PhD, a clinical psychologist who practices in Highland Park. "Much of what is asked for is inappropriate, and the people reviewing the information are not at my level of training, experience, or licensing."

Predictably, these changes have struck at practitioners' incomes.

**AN ESTIMATED
60 TO 70 PERCENT OF
ANXIETY CASES
ARE BEING TREATED
BY PRIMARY CARE
PHYSICIANS.**

Many professionals, especially those new to the field, have had to accept lower fees in exchange for a reliable flow of managed care referrals. The average fee for an outpatient psychiatric office visit dropped by 7 percent in real dollars between 1991 and 1996, from \$100 to \$93. Under the headline, "Survey: Psychologist Incomes Plummet," the *National Psychologist* described in its July 1998 issue a "perilous descent" in annual income from \$86,200 in 1995 to \$73,850 in 1997. The same survey found that roughly 40 percent of responding psychologists had seriously considered leaving the profession in the last six months. Academic departments of psychiatry are reporting growing difficulty in filling psychiatric residencies.

At the same time, the emergence of new and seemingly effective antidepressants, anti-anxiety drugs, and other psychotropic medications has

led some practitioners to complain about being "medication consultants" rather than therapists. The appropriate use of these medications is debated in the mental health community, but the most comprehensive study of therapeutic outcomes, published in *Consumer Reports* last year, suggests that the best treatment protocol might involve a combination of therapy and monitored medications. Many mental health professionals argue that insurance companies prefer the medication route because it is cheaper than moderate or long-term psychotherapy.

As a result, a larger part of the treatment burden has fallen on primary care physicians, who may be too busy to monitor patient compliance with use of medications or referral to an unfamiliar psychotherapist. "An estimated 60 to 70 percent of all cases of anxiety today are being treated by primary care physicians," says Stephen Feldman, PhD, a clinical psychologist and senior vice-president of PsychPartners, a developer of disease management programs and integrated delivery systems. "A significant proportion of patients who come in with medical problems have conditions that are exacerbated by underlying psychological issues."

Given the shrinking value of mental health benefits, turf wars have intensified around scope of practice issues. Psychologists have turned to state legislatures—so far, unsuccessfully—to enact legislation that would enable them to prescribe drugs. Recently, legislators in Hawaii and California rejected bills, opposed by psychiatrists and academic psychologists, that would have granted psychologists prescription privileges. Likewise, efforts by psychiatrists to deny psychologists the right to diagnose and treat mental illness were defeated in the New York and California legislatures.

Mental health professional organizations and advocacy groups forged a more united front to gain passage of the 1996 Mental Health Parity Act. This law, which also was supported by the AMA, prohibits employers and insurance companies from applying lower limits on mental health benefits than on surgical and medical benefits.

Thus far, however, the Mental Health Parity Act has promised more than it has delivered. The law, which went into effect on January 1,

1998, exempts employers and health plans whose total costs increase by 1 percent or more as a result of expanded mental health coverage. The Act neither defines costs nor outlines the exemption process, and the Clinton Administration created a major loophole by permitting employers to gain exemptions through estimates of future costs. Advocacy groups, along with a legislative sponsor of the law, want exemption applications to be evaluated only after one year of compliance with the legislation.

Parity legislation has languished in the New Jersey Legislature, drawing opposition from business and insurance groups concerned about increasing health care costs. Two recent studies suggest that these concerns may be exaggerated. A 1998 study by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) found that parity coverage would raise total premiums by less than 0.2 percent

for substance abuse, and 3.6 percent for all mental health services. Another report, published in *JAMA* in 1997, found that mental health parity would increase managed care group health insurance by roughly one dollar per enrollee per year.

Most mental health professionals believe that employers and managed care organizations are shortsighted and self-defeating in regard to the cost issue. They cite studies indicating that for every dollar spent on treating such problems as depression and anxiety through outpatient psychotherapy, employers save three dollars in medical utilization and various indirect costs. They point to a growing body of research that links stress, depression, and loneliness to greater risk of stroke, cardiovascular disease, and cancer. They contend that limiting the range of treatment options is both unwise and unfair, making intensive psychotherapy a privilege reserved to the rich or to those with "cadillac" health insurance coverage.

Or, as Feldman put it: "If you had ten chief executive officers of managed care companies in a room and asked them what type of psychological treatment they would select for themselves or a family member, what do you think they would choose for treatment?"

**SURVEY RESPONDENTS
SAID THEY
CANNOT OBTAIN
HIGH-QUALITY
INPATIENT MENTAL
HEALTH CARE.**

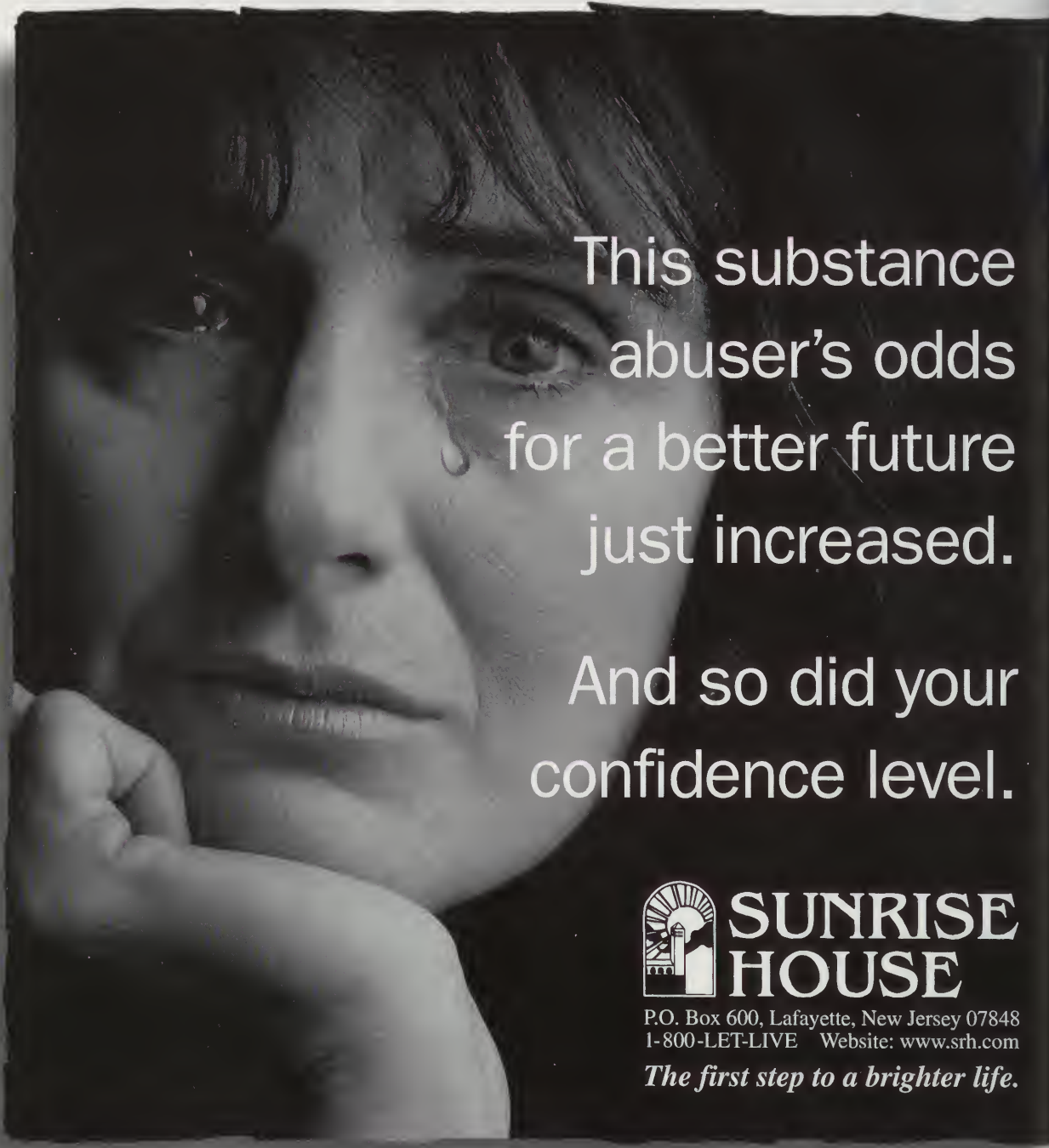
Whether it's an alcohol or drug problem, count on Sunrise House for expert help.

For 14 years, hundreds of tri-state area doctors have trusted us to offer their patients the most effective, caring treatment and a chance for a better life.

Set in the scenic hills of northwest New Jersey, we're a licensed, nonprofit specialty hospital with a nationally known commitment to quality—including Accreditation with Commendation by the JCAHO. Our comprehensive programs include inpatient and outpatient services, after-care and family support.

And our experienced staff of doctors and specialists works closely with referring physicians to ensure continuity of care at every stage of treatment.

Sunrise House. High-quality, affordable treatment you can trust. For information, call us at 1-800-LET-LIVE or (973) 383-6300.



This substance
abuser's odds
for a better future
just increased.

And so did your
confidence level.



**SUNRISE
HOUSE**

P.O. Box 600, Lafayette, New Jersey 07848
1-800-LET-LIVE Website: www.srh.com

The first step to a brighter life.

Sunrise House is a preferred provider of most major insurance companies and HMOs.
We will process insurance benefits verification and precertification.

WHOM TO BELIEVE?



A REVIEW OF RECENT MALPRACTICE CASES

SOME FOLKS HAVE CREDIBILITY, AND SOME FOLKS DON'T. IF YOU ARE A GOOD POLITICIAN, YOU CAN MAINTAIN CREDIBILITY BY TALKING AROUND ISSUES THAT CANNOT BE ADDRESSED HEAD ON. BUT, IN THE COURTROOM, RULES OF EVIDENCE AND JUDGES' INTOLERANCE FORCE DIRECT ANSWERS. CONSIDER THE REALM OF MEDICAL MALPRACTICE CASES RECENTLY TRIED IN THE GARDEN STATE AND SUMMARIZED IN *NJ JURY VERDICT REVIEW & ANALYSIS*.

N' E. Weisfeld

THE MYSTERIOUS CONSULTS

A neurologist received the referral of a married man in his 30s, a college graduate, who had suffered an embolic stroke. The patient's established history of cocaine use led the neurologist, especially in view of the patient's young age, to suspect that a cocaine-induced spasm had created a thrombus, or blood clot, which probably obstructed the heart and then traveled to the brain and kidneys.

The injury to the kidneys resolved. An electrocardiogram was normal. To prevent further clots, the neurologist

prescribed Coumadin®. An electrocardiogram repeated after one year also was normal, but the neurologist, after initially deciding to discontinue Coumadin®, maintained the regimen.

After a third EKG, however, the physician withdrew Coumadin®. At this point the patient was earning an average of almost \$1,000 per week as a beer salesman and, according to subsequent reports, missed only one day of work in two years at his job.

Sixteen months after Coumadin® use was discontinued, the patient suffered a second stroke, more severe than the

first. Blaming the event on the discontinuation of Coumadin®, the patient sued the neurologist for malpractice.

At trial, an expert cardiologist testifying for the plaintiff asserted that the third EKG showed dyskinesia of the left ventricular apex, which could cause blood to collect in a pool and lead to the formation of a thrombus. According to the expert, the EKG findings were consistent with stasis of blood.

The expert declared that the second stroke clearly was related to Coumadin® withdrawal. Commenting that he had

never before testified against a malpractice defendant, the expert stated that Coumadin® was very strongly indicated if the patient still was using cocaine. The expert quantified the risk of a second stroke as 40 percent with cocaine and without Coumadin®, 20 percent without cocaine or Coumadin®, 4 percent with cocaine and Coumadin®, and 2 percent without cocaine but with Coumadin®.

Denying that he used cocaine during the interval between his two strokes, the plaintiff presented to the jury with noticeable balance and speech deficits. Evidence was adduced that the plaintiff's IQ had sunk to 80. The damage was said to be permanent. The plaintiff also testified that he was on a regimen of an anti-seizure medication, Tegretol®.

The plaintiff's wife testified that the plaintiff's behavior had become erratic, frightening their two young children, for example, by turning all televisions and radios in the house to full volume. He also disappeared for long periods. Concern for the children, one of whom was frequently afraid to leave his room, had led her to arrange for the plaintiff to

live with his mother. The couple sold their house, and the wife moved with the children to an apartment where she shared a room with her daughter.

The defendant explained that he had reversed his earlier decision and maintained the patient on the Coumadin® following the second EKG because, after conferring with a cardiologist, he determined that the test was suspicious. He could not, however, produce the cardiologist, who might have been a now-deceased colleague. The defendant's notes did not explain the decision.

A cardiac consultation also was the basis for the decision to withdraw the Coumadin® after the third EKG, the defendant further recounted. He could not recall the name of the cardiologist or produce a record of the referral or the consultant's report. The cardiologist who prepared the EKG report insisted that he would not have advised the defendant that the test was normal.



The jury specifically found that the plaintiff was using cocaine until the second stroke. The jury determined that 18 percent of the patient's injuries were caused by cocaine use as an underlying condition. It then awarded \$3,600,000 to the plaintiff and \$3,200,000 to his guiltless spouse. These sums were reduced by 18 percent.

TWO COUPLES

The reader may recall the snowy winter of 1994. On a Friday afternoon during a snowstorm, a couple was shoveling snow at their home. The husband, a machinist in his 40s, previously had a cough and some chest pain. After finishing shoveling, he continued to experience chest pain, began to perspire heavily, and felt short of breath. His wife telephoned his internists, who were husband and wife.

At this point, subsequent accounts diverged. The patient's wife asserted that she placed the call at 2:15, spoke to the woman internist, and was advised not to come to the physicians' office because it was closing early due to the storm. The physician prescribed a cough syrup.

Not so, said the physician. She recalled speaking to the patient and not to his wife. The internist said that she advised the patient to come to the office, but that he declined due to the adverse road conditions caused by the storm.

The patient's wife drove to the pharmacy to pick up the prescription. Another cough syrup prescription was called in to the pharmacy later in the weekend. On Monday, the patient did visit the office and saw the male internist, who diagnosed bronchitis.

On Tuesday morning, the patient's wife summoned an ambulance, which transported the patient to a hospital where he was stabilized. A coronary infarct and pulmonary edema were diagnosed. Three days later triple bypass surgery was performed at another hospital. The patient sued both physicians for malpractice for failing to see the patient before Monday and failing to order an EKG.

An expert internist with a subspecialty practice in cardiovascular disease testified for the plaintiff. The expert contended that the physicians should have seen the patient, especially in light of several risk factors in the patient's record, including diabetes, coronary artery disease, and elevated cholesterol. An EKG, added the cardiovascular expert, was plainly indicated and would have revealed changes. Addressing these changes might have prevented the heart attack.

PHYSICIANS SHOULD
EXERCISE CAUTION
BEFORE RELEASING
CONFIDENTIAL
PATIENT RECORDS.

At the hospital, the patient's wife furnished information consistent with her version of events and specifically with her Friday conversation with the woman physician. The patient's wife remarked that she and her husband would not have declined a visit to the office because of the snowstorm yet travel to the pharmacy, which was approximately the same distance from their home.

Also, the patient's wife claimed that she had spoken several times over the weekend with the male internist, who advised her against going to the hospital, due to poor weekend staffing. According to the wife, the male physician ordered the second prescription when the first appeared not to be relieving the patient's symptoms.

Disputing the patient's wife's account, the male physician stated that he did not speak with her over the weekend, although he did not dispute the second prescription. According to him, the Monday visit

revealed bronchial symptoms but no shortness of breath.

Further, declared the male physician, enzyme levels that reflected a recent elevation further proved that the infarct began Tuesday. And, bypass surgery would have been necessary in any event, he added—a conclusion that the plaintiff did not dispute.

The plaintiff's counter to the defense's enzyme testimony was that enzyme levels rose only after cardiac damage was occurring. In claiming damages, the plaintiff noted that he returned to work nine months after the heart attack but stopped working three years later.

Who was to blame? The jury decided that the male internist did not negligently cause the plaintiff's injuries. The jury further determined that 55 percent of the injuries were attributable to the underlying cardiac condition. Negligence on the part of the woman internist, they found, was responsible for the remaining 45 percent. The jury assessed the husband's damages at \$500,000, to be reduced by 55 percent. It assessed the plaintiff's wife's damages at zero.

Mutually dissatisfied, both the plaintiff and defense filed post-trial motions. The jury's findings were said to be inconsistent.

And, what of the couples, fiercely attacked in court and then told by a

jury that one member of each couple was more convincing than the other? Perhaps the couples could empathize with the historian Thomas Carlyle and his assertive wife for receiving this taunt of Samuel Butler: "How good of God to let Carlyle and Mrs. Carlyle marry one another, and so make only two people miserable instead of four."

CHOOSING THE RIGHT EXPERT

In a car accident, a 25-year-old laborer struck his chest, occasioning a severe injury to the aorta. The patient's care was referred to a cardiothoracic surgeon, who decided on use of the "clamp and sew" method to repair the aorta. This method entails risk associated with disruption in the flow of blood. In the event, ischemia to part of the spinal cord did result, causing paralysis in both legs and depriving the patient of the capacity to maintain his livelihood.

Bringing an action against the surgeon, the patient alleged that the injury resulted from the loss of blood flow for one hour during the complicated procedure. Clamp and sew, maintained the plaintiff, should be used only for surgery that can be completed within half that time. The plaintiff contended that the surgeon was negligent in not

using a shunt to continue the blood supply during the procedure.

A wholly different view was offered by the defendant. When he opened the chest cavity and first observed the hematoma, stated the surgeon, he saw that a rupture in the aorta was imminent and that only the aorta's thin outer layer was still intact and functioning to keep the blood within the circulatory system. Inserting a shunt would normally take 20 minutes, he explained, during which the outer layer probably would have burst.

Moreover, said the surgeon, because the tear had extended into the aortic arch, the repair was time-consuming as well as emergent. Far from negligently causing the patient's injuries, the defendant argued, he had saved the patient's life.

An expert witness was called by the defense. The expert was the inventor of the shunt used in aorta repair surgery. Asked whether the shunt would have been appropriate in this

case, the expert responded in the negative. The jury found for the defense.

COMMUNICATION FAILURE?

A woman's first pregnancy was generally uneventful (medically speaking), but she was slightly post-term when going into labor. At 5:05 a.m. the charge nurse noted variable decelerations on the fetal monitoring strips and telephoned the patient's obstetrician, who concluded that the situation was properly under control.

At 5:30 a.m. the strips were read again, producing further concern. Another nurse changed the patient's position, administered oxygen, and increased the dosage of intravenous solution.

At 6 a.m. the patient began to vomit. The nurse at the bedside advised the charge nurse of the need to summon the obstetrician. At 6:20 a.m. the charge nurse made the call. The physician did travel to the hospital, where he tended to other business, asking another obstetrician to look in on the patient. Upon doing so, the second obstetrician immediately ordered an emergency cesarean section.

The baby, a girl, suffered hypoxia, apparently associated with a fetal-maternal bleed. Mild mental retardation ensued, along with hemiparesis on the right side, which restricted the right hand and arm to helper status only.



In a malpractice action the plaintiff contended that the patient's obstetrician should have come to the hospital in response to the charge nurse's first call and should have ordered a c-section in response to the second call. The plaintiff

further alleged that the charge nurse should have been more explicit during the first call in describing the emerging fetal distress and should have placed the second call immediately at 6 a.m. The plaintiff faulted the bedside nurse for not arranging for a call to the physician at 5:30 a.m. All these negligent failures, claimed the plaintiff, delayed the necessary surgery and caused the injuries to the baby.

An expert obstetrician-gynecologist testified for the plaintiff in support of the claims of negligence. The expert stated that the strips read at 5:30 a.m. showed late decelerations and a loss of beat-to-beat variability that signaled fetal distress.

Testifying for the defense, an expert pediatric neurologist asserted that low hemoglobin levels suggested that the bleeding was of long duration, possibly beginning several weeks before birth. If accurate, this contention suggested that the injuries would have occurred even if

MUTUALLY DISSATISFIED, THE PLAINTIFF AND THE DEFENSE FILED POST-TRIAL MOTIONS.

the c-section had been performed earlier.

But the plaintiff's expert countered that the neurologist's explanation was inconsistent with the lack of signs of fetal distress before 5:05 a.m. A subsequent transfusion caused a rapid rise in the hemoglobin level, noted the plaintiff's expert, which suggests that the level could fall rapidly as well.

A vocational expert testified for the plaintiff that the child, who was age 7 at trial, will have only very limited earning potential, compared with the \$500,000 to \$1,200,000 that she would have been able to earn without the disabilities. The plaintiff also described the child's limitations in daily activities, such as getting dressed.

The charge nurse defended her 20-minute delay in placing the second call to the obstetrician, pointing to concerns urgently expressed by the husband of another patient undergoing a premature delivery. The plaintiff responded that the

charge nurse either should have placed the call immediately or directed the bedside nurse to place the call.

The jury apportioned responsibility at 80 percent for the patient's obstetrician, 20 percent for the charge nurse, and 0 percent for the bedside nurse. The jury awarded \$1,400,000.

RELEASING PATIENT RECORDS

A Virginia Supreme Court decision, highlighted in the *Hospital Law Newsletter*, suggests that physicians and other health care providers should exercise great caution before releasing confidential patient records, even to their own attorneys.

A woman brought a malpractice action against a hospital in connection with the death of her baby shortly after delivery. The hospital shared with its attorney its records not only about the baby, but about the mother as well. The records at issue did not pertain to the circumstances involving the baby's care.

This provision of information came to light during discovery proceedings. The Old Dominion high court permitted the mother to recover damages for emotional distress.

Apparently, the justices did not believe the hospital's claim that the records were closely intertwined.

Mr. Weisfeld is deputy executive director, Medical Society of New Jersey.

CALENDAR

E V E N T

D A T E

L O C A T I O N

D e c e m b e r

Update in Gastroenterology, Hepatology, and Nutrition	December 11, 1998	College of Physicians and Surgeons, New York 212.781.5990
Domestic Violence Issues	December 12, 1998	St. Mary's Hospital, Passaic, AMNJ, 609.275.1911
Morbidity and Mortality	December 15, 1998	Jersey Shore Medical Center, Neptune, 732.776.4420
Abnormal Pap Smear	December 16, 1998	St. Mary's Hospital, Passaic, AMNJ, 609.275.1911
Endocrinology Lecture	December 16, 1998	VA Medical Center, East Orange, AMNJ, 609.275.1911
Medical Grand Rounds	December 23, 1998	VA Medical Center, East Orange, AMNJ, 609.275.1911
Interhospital Endocrine Rounds	December 30, 1998	University Hospital, Newark, AMNJ, 609.275.1911

J a n u a r y

Advances in the Diagnosis and Management of HIV/AIDS	January 6, 1999	St. Mary's Hospital, Passaic, AMNJ, 609.275.1911
Integrating TB Management with HIV-Infected Patients	January 6, 1999	Union Hospital, Union, AMNJ, 609.275.1911
Follicular Unit Transplantation	January 12, 1999	The Manor, East Orange, AMNJ, 609.275.1911
Lung Cancer	January 13, 1999	St. Mary's Hospital, Passaic, AMNJ, 609.275.1911
Medical Grand Rounds	January 13, 1999	VA Medical Center, East Orange, AMNJ, 609.275.1911
Interhospital Endocrine Rounds	January 13, 1999	University Hospital, Newark, AMNJ, 609.275.1911
NJ Society of Anesthesiologists	January 19, 1999	Forsgate Country Club, Jamesburg, AMNJ, 609.275.1911
Public Affairs Conference	January 20, 1999	MSNJ Headquarters, Lawrenceville, 609.896.1766

CD Investors: HIGH INCOME WITH LIQUIDITY

100% NO
LOAD

Prime Reserve Fund

Current 7-Day Yield†

4.84%

T. Rowe Price Prime Reserve Fund is a money market fund that offers you:

- Potentially higher returns than bank money market deposit accounts
- No withdrawal penalties—unlike bank CDs
- A sensible holding account for cash between investments

High income, low risk. Prime Reserve invests primarily in money market securities—U.S. government and foreign and domestic bank obligations—with the *highest credit ratings*. Short-term maturity, credit quality, and our intensive analysis help lower risk and generate potentially higher yields than bank money market deposit accounts. Unlike bank products, the fund does not offer a fixed rate of return and is neither insured nor guaranteed by the U.S. government.

Stability. The fund has maintained a stable \$1 share price* since its inception 21 years ago.

Minimum investment \$2,500. Free check-writing.** 100% no load.

**Call 24 hours for your
free investment kit
including a prospectus**

1-800-541-4633

www.troweprice.com

Invest With Confidence®
T. Rowe Price



Simple yield as of 11/9/98. Past performance cannot guarantee future results. There is no assurance the fund will be able to maintain the \$1 share price.

*\$500 minimum. Read the prospectus carefully before investing.
Rowe Price Investment Services, Inc., Distributor.

PRFO45370

INTERNATIONAL COLLEGE OF ACUPUNCTURE & ELECTRO-THERAPEUTICS

(Permanently Chartered by the University of the State of New York,
State Education Department)

ACUPUNCTURE & ELECTRO-THERAPEUTICS in Clinical Practice

1998-99 Seminars & Workshops

25 credit hours can be earned by attending

one three-day weekend (Friday-Sunday) session 9 am-7 pm

Dec. 11-13, 1998 Holiday Inn, Manhattan

Jan. 22-24, 1999 440 W. 57th St, NYC between 9 & 10 Ave.

Feb. 19-21, 1999 Hotel tel. 212-581-8100 during meetings

Mar. 19-24, May 14-16, June 18-20, 1999

In addition to holding 7-8 seminars & workshops per year, the International College of Acupuncture & Electro-Therapeutics organizes an Annual International Symposium every October at the School of International Affairs, Columbia University, NYC and publishes *Acupuncture & Electro-Therapeutics Research*, *The International Journal* quarterly, through Cognizant Communications and is listed by 15 major international indexing periodicals (*Index Medicus*, *Current Content*, *Excerpta Medica*, etc.), is recognized as a major leading journal in the field. The most prestigious and internationally recognized, "Fellow of the International College" (F.I.C.A.E.) will be awarded to members of the College who present a minimum of 2 original research papers during the annual International Symposium and publish them in the official journal, or who have made significant contributions in the field.

These seminars/workshops, int'l. symposium train physicians and dentists in the latest theories & techniques of manual & electro-acupuncture.

For information, contact Dr. Y. Omura, MD, ScD, FICAE, 800 Riverside Drive (8-1), NY, NY 10032; 212-781-6262, Fax 212-923-2279 or Dr. Richard Simon, PhD, 212-662-7022. All ICAE meetings are accredited by the New York State Boards for Medicine and Dentistry towards 300-hour requirement for the Acupuncture Certificate. Also eligible for AMA/CME Category I Credit. This activity implemented in accordance with ACCME, joint sponsorship CE Program MSSNY and SUNY Health Science Center, Brooklyn. MSSNY is accredited by the ACCME to provide CME for physicians. MSSNY designates this CME activity for category one credit towards the AMA/Physician's Recognition Award.

You take care of your patients. We'll take care of the health of your practice. Our group of health care accounting specialists provides the medical community with the right type of analysis and counseling to be successful.

Since we're dedicated to increasing your profitability, never simply reporting it, we'll see

to it that your practice stays healthy for many years to come. To experience our unique approach, please call Ira S. Rosenbloom, Managing Director, at 973-882-1100.

PRACTICE
GOOD FINANCIAL
MEDICINE.



Mintz Rosenfeld & Company LLC

Profitability Consultants • Certified Public Accountants

60 Route 46 East, Fairfield, NJ 07004

Tel: 973-882-1100 Fax: 973-882-1560

OUR FOCUS IS YOUR SUCCESS.

A L E N D A

E V E N T

D A T E

L O C A T I O N

J a n u a r y

Type II Diabetes	January 20, 1999	St. Mary's Hospital, Passaic, AMNJ, 609.275.1911
Endocrinology Lecture	January 20, 1999	VA Medical Center, East Orange, AMNJ, 609.275.1911
Interhospital Endocrine Rounds	January 20, 1999	University Hospital, Newark, AMNJ, 609.275.1911
Radiological Society of New Jersey and Diagnostic Radiology Section Meeting	January 21, 1999	Robert Wood Johnson Medical School, New Brunswick, AMNJ, 609.275.1911
Violent Patients: Handling and Preceding	January 27, 1999	St. Mary's Hospital, Passaic, AMNJ, 609.275.1911
Medical Grand Rounds	January 27, 1999	VA Medical Center, East Orange, AMNJ, 609.275.1911
Interhospital Endocrine Rounds	January 27, 1999	University Hospital, Newark, AMNJ, 609.275.1911

F e b r u a r y

Albert Siegel Symposium	February 3, 1999	St. Barnabas Medical Center, AMNJ, 609.275.1911
Renal and Pancreatic Transplant Update	February 3, 1999	St. Mary's Hospital, Passaic, AMNJ, 609.275.1911
Medical Grand Rounds	February 3, 1999	VA Medical Center, East Orange, AMNJ, 609.275.1911
Endocrinology Lecture	February 3, 1999	VA Medical Center, East Orange, AMNJ, 609.275.1911
Interhospital Endocrine Rounds	February 3, 1999	University Hospital, Newark, AMNJ, 609.275.1911
Retinoids in the Management of Acne and Photoaging	February 9, 1999	Schering Corporation, Kenilworth, AMNJ, 609.275.1911
Management of Peptic Ulcer Disease	February 10, 1999	St. Mary's Hospital, Passaic, AMNJ, 609.275.1911

POSITION AVAILABLE: EDITOR-IN-CHIEF

The Medical Society of New Jersey (MSNJ) announces the position of Editor-in-Chief of its monthly print organ, *New Jersey Medicine (NJM)*. MSNJ's Strategic Plan (1995) includes an objective to "advance [NJM] as the major health policy publication in New Jersey and expand its readership beyond the membership and physician community."

The part-time position includes control of the peer review process, furnishing of an assigned or personally drafted monthly editorial, and participation in decisions about commissioned pieces, editorial format, design, advertising, circulation, and activities of the NJM Review Board and the MSNJ Council on Communications.

MSNJ members interested in the position are invited to submit a hard-copy resume and cover letter directed to the attention of Ms. Diana C. Gore, Director-Officer Services, at MSNJ, 2 Princess Road, Lawrenceville, NJ 08648, before January 15, 1999. They should emphasize either in their resume or the cover letter their scientific publication experience.

NOTICE ON V.E.B.A.'S

**BOOTH V. THE COMMISSIONER,
6/17/97 JUDGE S. LARO**

THE U. S. TAX COURT UPHELD THE LEGALITY OF VEBA'S AND TAXPAYER RIGHTS TO SECURE BENEFITS THROUGH TAX DEDUCTIBLE VEBA CONTRIBUTIONS. PROPER VEBA CONTRIBUTIONS REDUCE TAXES AND ARE NOT CONSIDERED DEFERRED COMPENSATION OR CONTRIBUTIONS TO PENSIONS.

THE KIRWAN COMPANIES

402 Middletown Blvd., Ste. 202 Langhorne, Pa. 19047
(215) 750-7616 (215) 750-7791 Fax



Excel Business Park

501 Prospect Street

Unit 96

Lakewood, NJ 08701

Phone: 732-886-0600

Fax: 732-886-0911

"The overall effect is total customer satisfaction."

- Medical/Dental Cabinetry
- Nurses Stations
- Reception Desks
- Nourishment Centers
- Medical/Dental Procedure Carts
- Computer Desks
- Monitor Cabinets
- Chart Racks
- Corian® Solid Surfacing
Certified Fabricator #C-5112
- Space Planning/Layout

THE MEDICAL SOCIETY OF NEW JERSEY CLASSIFIED ADVERTISEMENT INSERTION REQUEST

RATES (Placement in New Jersey *MEDICINE* OR on WEB Site)

New Jersey *MEDICINE*

<http://www.msnj.org>
WEB Site

Per Month—Non-Members		
Minimum 45 words	\$ 45.00	
plus each word		
over 45 words	\$ 1.00	
Per Month—Members		
Minimum 45 words	\$ 30.00	
plus each word		
over 45 words	\$ 1.00	
Per Month—		
Minimum 45 words		\$ 45.00
plus each word		
over 45 words		\$ 1.00

(Placement in New Jersey *MEDICINE* AND on WEB Site)

New Jersey *MEDICINE*

<http://www.msnj.org>
WEB Site

Per Month—Non-Members		
Minimum 45 words	\$ 45.00	\$ 36.00
plus each word		
over 45 words	\$ 1.00	\$.80
Per Month—Members		
Minimum 45 words	\$ 30.00	\$ 36.00
plus each word		
over 45 words	\$ 1.00	\$.80

PREPARE YOUR COPY ON A SEPARATE PAGE AND ATTACH TO THIS ORDER FORM

INSERTION AUTHORIZATION

Name _____ MSNJ Member? Yes _____ No _____
 Company _____ Telephone Number _____
 Address _____ Fax Number _____
 City _____ State _____ ZIP _____
 New Jersey *MEDICINE* Issues _____
 Web # of 30 Day Insertions _____

New Jersey *MEDICINE*

Non-Member
 Minimum 45 Words \$ _____ 45.00
 + Each Add'l Word @\$1.00 \$ _____
 Per Issue \$ _____
 X Number of Issues _____
 AMOUNT DUE \$ _____

MSNJ WEB SITE

Non-Member or Member
 Minimum 45 Words \$ _____ 45.00
 + Each Add'l Word @\$1.00 \$ _____
 Per Month \$ _____
 X Number of Months _____
 AMOUNT DUE \$ _____

New Jersey *MEDICINE*

Member
 Minimum 45 Words \$ _____
 + Each Add'l Word @\$1.00 \$ _____
 Per Issue \$ _____
 X Number of Issues _____
 AMOUNT DUE \$ _____

MSNJ WEB SITE WITH NEW JERSEY *Medicine* Placement

Non-Member or Member
 Minimum 45 Words \$ _____
 + Each Add'l Word @\$.80 \$ _____
 Per Month \$ _____
 X Number of Months _____
 AMOUNT DUE \$ _____

TOTAL DUE \$ _____ ALL CLASSIFIED ADS MUST BE PRE-PAID

Please make check payable to "Medical Society of New Jersey"

Mail to: Classified Ad Department
 370 Morris Avenue
 Trenton, NJ 08611

Tel: 609-393-7196
 Fax: 609-393-3759

THE SIGN OF GREAT COVERAGE.



WHEN IT COMES TO FINDING PROFESSIONAL LIABILITY INSURANCE, ALL ROADS LEAD TO GULF ATLANTIC

The need for comprehensive professional liability insurance has never been greater. And with so many new companies sprouting up almost daily, finding the right plan isn't getting any easier. That's why the Gulf Atlantic Professional Liability Program might be the protection you need, and have been looking for.

For over twenty years Gulf Atlantic has been successfully providing insurance protection for the medical community. And since Gulf Atlantic policies are underwritten by Clarendon National Insurance Company, your coverage comes with an **A.M. Best A- (Excellent) rating**.

So while other carriers dot the landscape and attempt to block your view, Gulf Atlantic will help you navigate through the many choices by providing a program designed specifically for your needs.

For more information on how you can arrive at your destination safely, contact **The Stewart Group, 107-A Corporate Blvd., South Plainfield, NJ 07080, (908) 755-0066.**

UNDERWRITTEN BY



The Gulf Atlantic Professional Liability Program is underwritten by Clarendon National Insurance Company which has an A.M. Best A- (Excellent) rating.



The Gulf Atlantic Professional Liability Program

GULF ATLANTIC INSURANCE SERVICES, INC.

General Agent

1-800-739-4242

CLASSIFIED ADS

100 OPENINGS PHYSICIANS (MULTIPLE SPECIALTY)

PODELL MEDICAL CENTER

Wanted: Physicians who integrate conventional and holistic medicine; full or part-time; primary care or specialties. Our strengths: CFS, fibromyalgia, anxiety, depression, cancer. Would welcome these skills or other programs of excellence e.g. headache, A.D.D., geriatrics, women's health. Call 908-464-3800.

110 OPENINGS PHYSICIANS (ALPHABETICAL BY SPECIALTY)

BC/BE ANESTHESIOLOGIST

Pain Management Only—New Jersey (Central/Northern—½ hr from N.Y.C. Outstanding private practice opportunity for motivated BC/BE Anesthesiologist. Pain Fellowship is a plus. F/T or P/T. Most established pain group in the state. No night call or w-ends. Excel. Compensation. Avail immed. Fax short C.V. & cover letter to 732-651-0375.

BC/BE INTERNAL MEDICINE

BC/BE Internal Medicine Morris County. Well established private practice on staff of Morristown Memorial Hospital seeking PT/FT associate. Fax Resume 973-514-1056.

BC/BE INTERNAL MEDICINE

Seeking a BC/BE eager internist to join busy primary care office in beautiful Red Bank, NJ (GSP Exit 109)—Competitive salary, and benefits. Group coverage with ½th on call. Fax short CV and cover letter to 732-219-1968. Would consider part time situation. Recent graduate welcome!

130 OPPORTUNITY WANTED

FAMILY PRACTICE

Family Practice—Board Certified. Physician seeks professional opportunity. 973-761-7077.

GENERAL PRACTICE—ER

52 years old, 23 years medical practice in General Practice and small ER's; seeks fulltime/part-time/locum tenens work. Not board-certified or eligible; only 1 year PG. Licensed MO, NJ, Puerto Rico, Virgin Islands. ACLS only. Foreign Graduate (Spain 1975). 314-428-4032.

INTERNIST

Physician: Board Eligible Internist. Interested in part-time (20 hours or less) work, in either a Medical Clinic, Out Patient Department, Medical Office, Health Care Center or Primary Care Center. Evenings possible. Completely Fluent in Spanish and English. Reply to: Box #141, New Jersey MEDICINE, 370 Morris Avenue, Trenton, NJ 08611.

200 PRACTICE FOR SALE

GENERAL ENT PRACTICE

N.J. Gen ENT practice, solo, in own building, established 28 yrs, South Jersey Shore area, 15 min. to Atl. City, 1 hr to Phila. Enjoy the shore, fishing, etc. Good opportunity. Call (609) 823-4273.

PEDIATRIC PRACTICE

Hudson County. 37 year old Pediatric Practice for sale. 2700 sq. ft. Office building with onsite parking. Practice sees 15,000 patient visits per year. Centrally located to major Hudson County hospitals. Computerized office, fully staffed, participates with many HMO's. For additional information, please contact: Mary Ann Hamburger, Phone: 973-763-7394; Fax: 973-763-8339.

300 OFFICE RENTALS AND LEASES

EDISON

Office Space—Edison Medi-Plex Building opposite J.F.K. Hosp. Fully equipped, turn-key. Rent day, full day, night. 732-494-6300.

EDISON

Modern Medical Office Space—Sublease Up to 2000 Square Feet. Fully equipped with on-site Surgery Center available. Suitable for Endoscopy, Surgical procedures, etc. Call Denise—732-549-2975.

EDISON

2 Office Suites, available 4/1/99 (1766 & 1214 sq ft). Set-up for medical office. X-Ray apparatus available (1,766 sq ft office). Very attractive building and offices. 732-549-7712.

ELIZABETH

Fully operative office at 430 Morris Ave (optimal location). Border of Elizabeth & Union. Fully equipped including X-Ray & fully furnished. Ample parking in private lot. Avail immed. Weichert 973-376-4545. Lanie or Kari.

LAKE HOPATCONG— MORRIS COUNTY

Medical Office Space. 2,000 Sq. Ft. Fully equipped. Occupied 35 years. Ideal for partnership or small group. Lake Hopatcong. 973-663-5306.

MARLBORO

Medical Complex—Fully equipped 1200 Square Feet of Medical Office space for Lease—Excellent Location—Call Dawn—732-548-3200

MILLBURN

Medical Arts Building. Millburn Avenue. Fully equipped, turn key. Rent day, ½ day, night. Call 973-376-8670.

310 OFFICES TO SHARE

NEW PROVIDENCE

The Podell Medical Center—New Providence, NJ. Physician wanted to share professional modern 1900 sq. ft. medical office space medical office & staff; Judy 908-464-3800.

500 MEDICAL EQUIPMENT FOR SALE

MOBILE VASCULAR LAB

Life Sciences "modulab" mint condition. Modules: Arterial, Venous PVR, CW/Doppler PPG, Phonoangiogram, probes, 5 pairs cuff, stereo headphones, remote, foot pedal, color screen, Fujitsu color printer, current software archiver, add'l modules available, custom wheeled cart, free company tech training. \$13,500. Fully deductible this year. Profitable! Call 609-384-9000.

520 NEW EQUIPMENT— LEASING/FINANCING

EQUIPMENT LEASING/FINANCING

HPSC specializes in financing healthcare practice equipment, working capital, leasehold improvements, supply contracts, start-ups. Low competitive fixed rates. Response within an hour, by phone or fax. Over 72,000 doctors financed with incredible service! \$150,000 application only. All contracts funded, serviced in house. We do not sell your contract to disinterested third parties. On practice acquisitions, buy-ins, we finance up to 100% of selling price. Apply over the Internet; www.hpsc.com (secure site)! HPSC Financial Services 800-225-2488, Fax 800-526-0259.

900 MISCELLANEOUS

INTERNET SERVICES

Internet Services—Are you using the Internet to stay up to date or earn CEU's? Interested in developing a web site but not sure where to start? Call 609-631-8529 to schedule a FREE session on using the Internet to enhance your practice.

OFFICE SPACE—RED BANK

Looking for 1-3 physicians any specialty, preferably internal medicine, family practice, dermatology, allergy,) to share with existing physician.

either co-owner or lease.

,600 sq. ft. allergy testing, cardiology, minor surgery on premises. Modern turn key facility.

(732) 747-5306

EMERGENCY PHYSICIANS

Emergency Physician Associates, a Team Health affiliate, is seeking quality ED physicians for a variety of practice opportunities in NJ, PA, DE, MD, NC and NY.

We offer physicians competitive compensation, flexible schedules, malpractice insurance, a variety of practice settings, and supportive Medical Directors.

Interested candidates may call

1-800-848-EPA-1.

VICE PRESIDENT OF MEDICAL AFFAIRS

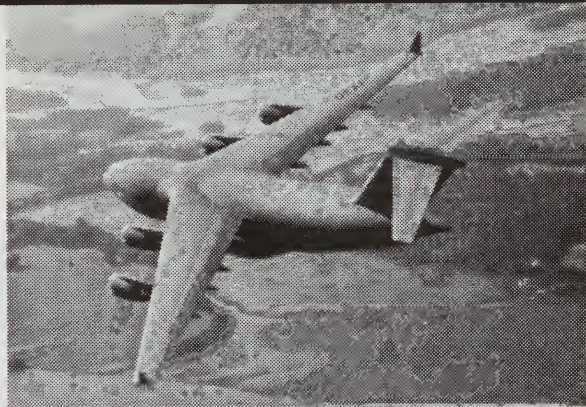
Bayonne Hospital, a progressive 299 bed acute care community hospital located in Hudson County, is currently seeking a dynamic, highly motivated individual to fill the position of Vice President of Medical Affairs. The successful candidate must be a licensed physician in the State of New Jersey and board certified in his/her field of practice. He/she will have broad experience as an attending physician with excellent clinical and administrative experience.

Reporting to the President and CEO, the major responsibilities of this full time position will include acting as liaison between the Medical Staff and administration, supporting the President of the Medical Staff, assuming responsibility for quality improvement and ensuring Medical Staff compliance with regulations for the State Department of Health, Joint Commission on Accreditation, as well as all other regulatory agencies.

Bayonne Hospital is an affiliate of Atlantic Health System, one of the largest healthcare networks in New Jersey. For immediate consideration, please mail or fax resume to Bonnie Keeler, M.D., Russell Reynolds Associates, 200 Park Avenue, New York, NY 10166. Phone: (212) 351-2000; Fax: (212) 286-1863; E-mail bkeeler@russtreyn.com.

PHYSICIANS

**TAKE YOUR
MEDICAL
CAREER
ABOVE &
BEYOND**



APN 25-801-0002

If you're a physician looking for a change of pace above and beyond the ordinary, consider becoming a commissioned officer/physician with the Air Force Reserve. As in civilian life, Air Force Reserve physicians provide critical and preventive care and vital clinical services.

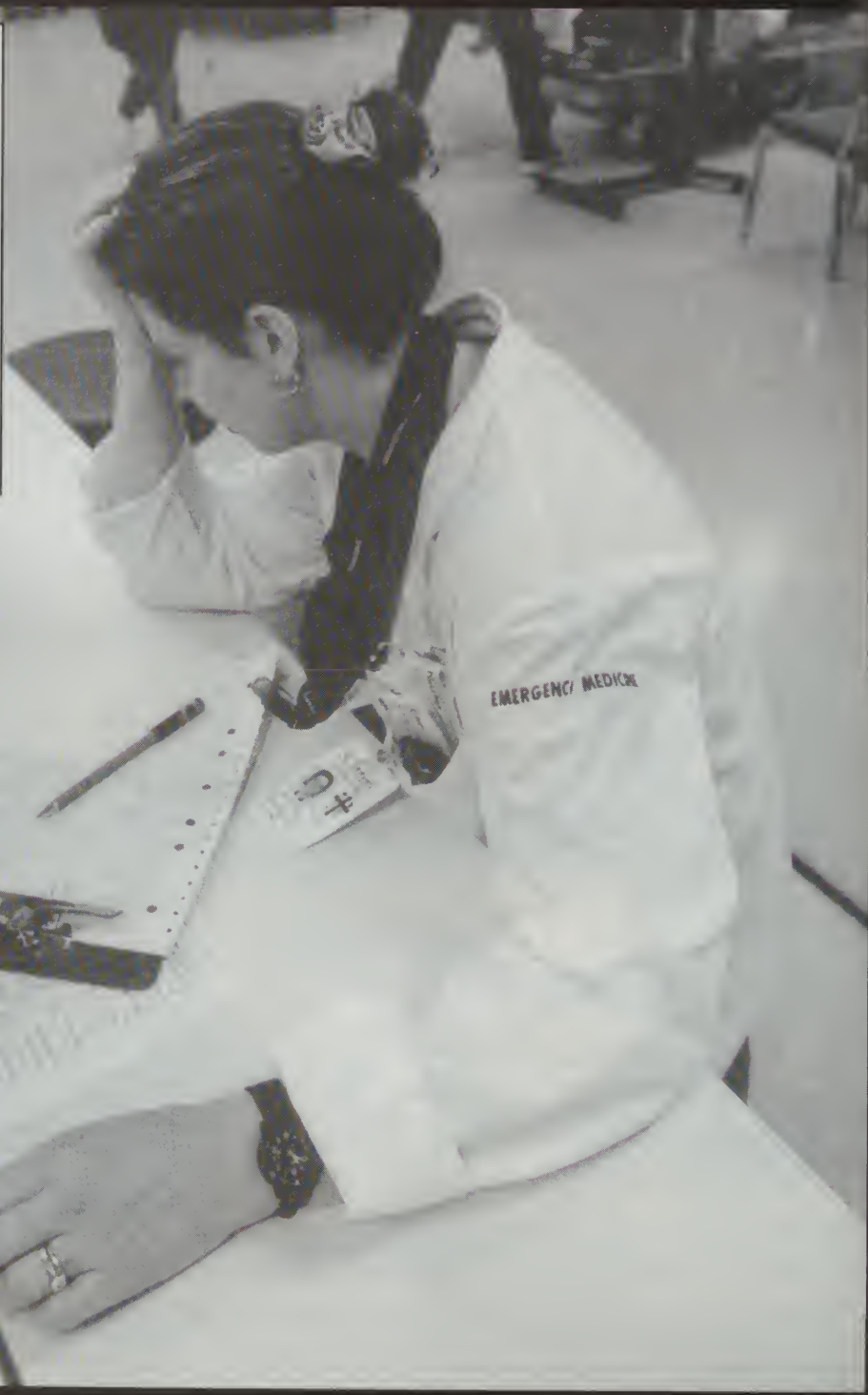
Moreover, as a Reservist, your medical expertise can take you around the globe and into real-world scenarios that will take healing above & beyond. Air Force Reserve physician/officers hold a position of special trust and responsibility. Combined with training opportunities in areas such as Global Medicine and Combat Casualty Care and paid CME activities, you will find yourself among an elite group of health care providers. All it takes is one weekend a month and two weeks per year. Feel the pride of doing something above and beyond for your country while adding a new dimension to your medical career.


**AIR FORCE
RESERVE**
ABOVE & BEYOND

Call 1-800-257-1212 Or visit our web site at www.afreserve.com

Photo Finish

From the variety of cases that pass through the doors to the piles of paperwork that must be completed, practicing emergency medicine can be exhausting. Grabbing just a moment to collect thoughts or enjoy a deep breath, like attending ER physician Ellen Leavell, MD, from St. Peter's University Hospital and Health System, helps put many doctors back on track.



We welcome contributions to Photo Finish (color or black-and-white). Please include a 50-word description of the photograph. Send to Editor, New Jersey Medicine, Two Princess Road, Lawrenceville NJ 08648. Photographs will be returned.